DOCUMENT RESUME

ED 336 557 CE 058 923

AUTHOR	Pratt, Clara; And Others
TITLE	Perspectives on Aging: Bridging the Generation Gap. Oregon Home Economics Curriculum Model.
INSTITUTION	Oregon State Univ., Corvallis.
SPONS AGENCY	Oregon State Dept. of Education, Salem. Div. of Vocational Education.
PUB DATE	Aug 86
NOTE	251p.
PUB TYPE	Guides - Classroom Use - Teaching Guides (For Teacher) (052)
EDRS PRICE	MF01/PC11 Plus Postage.
DESCRIPTORS	*Aging (Individuals); Basic Skills; Communication Skills; Community Resources; Community Services; Demography; *Educational Gerontology; Family Life; *Family Relationship; High Schools; Occupational Home Economics; Older Adults; Student Volunteers; Teaching Guides; Well Being

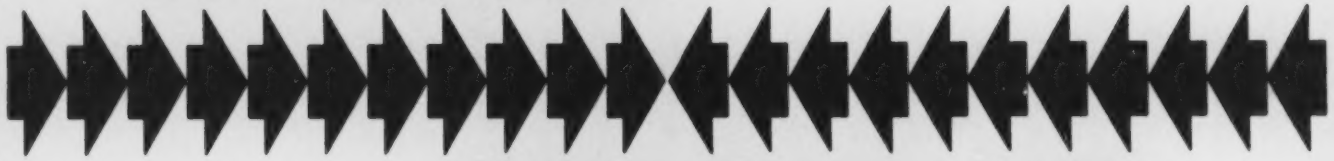
ABSTRACT

This gerontology curriculum model for high school family life programs in Oregon is organized by concepts, objectives, strategies, resources, generalizations, and evaluation techniques. There are eight curriculum concepts and objectives in this guide: (1) attitudes; (2) factors affecting aging; (3) demographics; (4) well-being in later life; (5) communication skills; (6) family relationships; (7) community resources; and (8) service learning. The curriculum concepts are numbered. The resource materials for each objective are indexed with the same number. Each objective contains a generalization, strategies, and resources. Each concept section may contain tests, answers, readings, and learning activities. In addition, this guide contains a glossary of terms and list of resource materials. (NLA)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED336557

PERSPECTIVES ON AGING:



BRIDGING THE GENERATION GAP

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

SAdler

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CE058923

Oregon

Home Economics

Curriculum Model

BEST COPY AVAILABLE

Perspectives in Aging: Bridging the Generation Gap curriculum model may be purchased from:

Curriculum Model
College of Home Economics
Oregon State University
Corvallis, Oregon 97331

Price: $12.00

Oregon State University is an Affirmative Action Equal Opportunity Employer and complies with section 504 of the Rehabilitation Act of 1973.

PERSPECTIVES ON AGING: BRIDGING THE GENERATION GAP

Developed by

Clara Pratt, Ph.D.
College of Home Economics
Oregon State University
Corvallis, Oregon

Joanne Miksis
Home Economics
Churchill High School
Eugene, Oregon

Jan Preedy
Home Economics
Thomas Senior High School
Hillsboro, Oregon

Joan Trapp
Home Economics
Cleveland High School
Portland, Oregon

Published by
College of Home Economics, Oregon State University
Corvallis, Oregon 97331

Through the auspices of
Consumer Homemaking Education Funds
Division of Vocational Education
Oregon Department of Education
700 Pringle Parkway SE
Salem, Oregon 97310

August 1986

NONDISCRIMINATION STATEMENT

It is the policy of the Oregon Department of Education that no person be subjected to discrimination on the basis of race, national origin, religion, sex, age, handicap, or marital status in any program, service, or activity for which the Oregon Department of Education is responsible. The Department will comply with the requirements of state and federal law concerning nondiscrimination and will strive by its actions to enhance the dignity and worth of all persons.

DISCLAIMER STATEMENT

This Resource Guide was developed pursuant to a grant from the Oregon Department of Education. However, the opinions expressed herein do not necessarily reflect the position or policy of the Oregon Department of Education, and no official endorsement should be inferred.

ACKNOWLEDGEMENTS

Information was gathered from many sources in developing this curriculum guide. Of particular value were materials developed by Vicki Schmall, Ph.D., gerontology specialist for the Oregon State University Extension Service. The Handbook for Instruction in Aging in the California Public Schools (K-12) was also very useful in developing curriculum concepts.

Colleen Mileham, project associate, directed the field testing, evaluation and final dissemination of the gerontology curriculum model. Agnes Ferngren, project secretary, typed and assisted in the dissemination of this guide.

TABLE OF CONTENTS

Page

Preface for Curriculum Models 3

Rationale 4

Philosophy of Education on Aging 5

Definition of an Elder 7

How to Use this Guide 8

Essential Learning Skills 9

Summary of Curriculum Concepts and Objectives 17

CONCEPTS

#1: Attitudes 21

Resources for Concept #1 27

#2: Factors Affecting Aging 51

Resources for Concept #2 55

#3: Demographics 57

Resources for Concept #3 61

#4: Well-Being in Later Life 85

Resources for Concepts #4 95

#5: Communication Skills 139

Resources for Concepts #5 145

#6: Family Relationships 189

Resources for Concepts #6 193

#7: Community Resources 247

Resources for Concepts #7 253

#8: Service Learning 261

Glossary of Terms 265

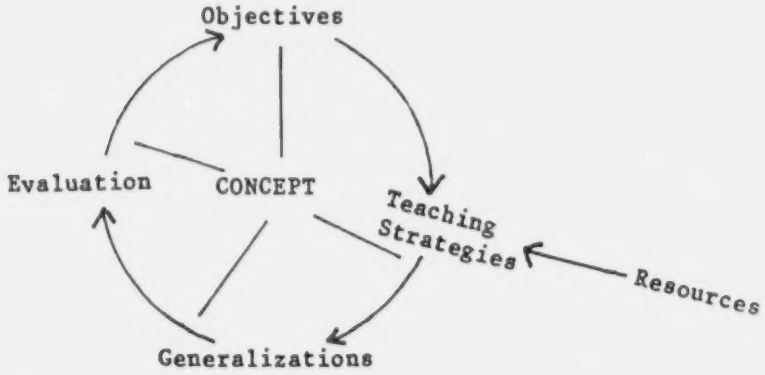
Resource Materials List 267

PREFACE FOR CURRICULUM MODELS

The primary goal for this curriculum model is for students to achieve at the higher cognitive, affective and psychomotor levels, that is, to be doers of complex tasks and to analyze facts, figures and principles, evaluate options, apply principles and synthesize data from many sources.

We chose a conceptual model to teaching in order to implement this goal. The content in this guide is organized by:

concepts:	big ideas, with many facets;
objectives:	stated in terms of <u>student</u> behavior and in measurable terms;
strategies:	activities sequenced and ultimately matched to the level of the objective for the lesson(s);
resources:	an array of objects, materials, experiences and people which can help the student to experience the "real thing" in relationship to the concept to be mastered;
generalizations:	summary statements of content; phrases which synthesize multiple facts and data into classification and relationship statements.
evaluation techniques:	assessment strategies matched to the level of mastery indicated by the objective.



The model leaves lots of room for the creativity of the teacher. Students who are thinkers and problem-solvers and not rote memorizers are the desired end product.

RATIONALE FOR THE GERONTOLOGY CURRICULUM

One goal of Home Economics is to provide education to improve the well-being of the family throughout the life cycle. This Gerontology Curriculum Model will help to achieve this goal and strengthen the total family life program currently being offered. The Gerontology Curriculum also provides an option for high school students to meet the requirements for graduation. Depending upon each individual school district's program goals for health education, the curriculum could potentially meet the graduation requirements in Health. Much of the content and many of the activities are also appropriate for middle school programs. In particular the concepts of attitudes and communication skills are important for middle school students.

As Home Economics looks toward the future, the emphasis on gerontology will help students develop an awareness of career options. With the changing demographics in the United States, there is a myriad of professional possibilities. As schools work to develop positive relations with the non-school community, this type of curriculum lends itself to building good public relations between schools and communities, a goal which is accomplished by completion of the student service learning component in the community setting.

A PHILOSOPHY OF EDUCATION ON AGING

Today, children can, on the average, expect to live to be seventy-five years of age. During their lives they will prepare for adulthood, help support society during their working years, and continue to live out their own ideas on aging. Educators working in the field of gerontology are seeking ways in which to improve the image of aging so that people can accept old age as a normal, anticipated, and vital part of the life span. Realistic concepts of aging can facilitate the transition into retirement and can help make retirement living satsifying.

As a result of technological advancements, the nature and structure of the family unit have changed. Many children do not have the opportunity to experience grandparent role models. The committee that formulated the handbook believes that:

--Young persons need a balanced view of aging, including positive images that will develop confidence in the aging processes to be experienced.

--As a means of passing on the culture from one generation to another, education can take some responsibility for providing role models and for offering accurate definitions of old persons from which students can begin to form some identity.

--Education on aging is a positive measure designed to help ensure the quality of life throughout one's life span.

The philosophy on which this handbook is based is that, given correct information, available resources, reasonable challenges, and an opportunity for creative instruction, teachers will develop a curriculum on aging as part of daily classroom activities. Instruction on aging should be concerned with the development of:

1. Life cycle education, including all the major processes and occasions of life: childhood, courtship, marriage, career, leisure, grief, and death.

2. Positive images of the elderly and the aging process.

3. An understanding that society changes and that each cohort of older persons is unique.

4. A realization that older persons are individuals seeking opportunities for individual choices, active community participation, and love and respect.

5. An appreciation for the accumulated wisdom and abilities of the elderly.

The handbook gives teachers practical help by providing (1) suggestions to develop concepts on aging that enhance classroom instruction, and (2) materials that will provide necessary background information for building values and positive self-concepts.

Each person develops a personal philosophy according to experiences acquired through living and learning. It is hoped that this handbook will open new vistas, challenge perspectives, and provide some answers to questions often raised on the subject of aging.

(Taken from "Handbook for Instruction on Aging" in California Public Schools K-12.)

Relationship of Essential Learning Skills and Perspectives On Aging Goals and Objectives

Essential Learning Skills for Oregon schools, developed under the leadership of the Oregon Department of Education, are to serve as a foundation for continued growth and development of all students in the academic environment and beyond. Recognizing the importance of Essential Learning Skills, the writers of this curriculum model developed a chart illustrating how the goals and objectives of Perspectives On Aging teach or reinforce these essential skills.

Personal Learning Objectives which meet ESSENTIAL LEARNING SKILLS for Oregon Schools ELS from Oregon Department of Education Salem, Oregon 1985-86

	ATTITUDES 1.1	1.2	1.3	1.4	1.5	FACTORS 2.1	2.2	2.3	2.4	DEMOGRAPHICS 3.1	3.2	3.3	WELL-BEING 4.1	4.2	4.3
1. Students will be able to demonstrate the use of vocabulary, speech, numerals and other symbol systems essential for effective communication, computation and problem solving.															
Students will be able to:															
1.1 Recognize words commonly used in grade-level materials, including subject areas.															
1.2 Determine meaning of unknown words commonly used in grade-level materials, including subject areas.	x	x	x	x		x	x								
1.3 Speak with standard pronunciation, appropriate volume, rate, gestures and inflections.															
1.4 Use number/numeric figures, letters, words, symbols and visuals to count, compute and communicate quantitative data.															
1.5 Recognize and use geometric patterns, relationships and principles to describe and classify.															
1.6 Recognize and use mathematical patterns, relationships and principles to quantify problems or make predictions.															
1.7 Estimate and measure quantities, define problems, develop hypotheses, select methods of computation, and solve problems.															
2. Students will be able to interpret the literal meanings of information presented in written, visual and oral communication.															
Students will be able to:															
2.1 Identify main ideas, supporting details, and facts and opinions presented in written, oral and visual formats.	x	x		x	x		x	x	x	x		x	x		x	x
2.2 Use instructional materials as basis for gaining knowledge and improving comprehension.	x	x	x	x	x		x	x	x	x					

2.2	2.1	1.7	1.6	1.5	1.4	1.3	1.2	1.1	
									4.4
	×								4.5
									4.6
									4.7
									4.8
									COMMUNICATION
×									5.1
×									5.2
×									5.3
×									5.4
×									5.5
									FAMILY RELATIONSHIPS
×									6.1
×									6.2
×									6.3
×	×								6.4
									COMMUNITY RESOURCES
	×								7.1
	×								7.2
									7.3
	×								7.4
									7.5
×							×		7.6
									SERVICE LEARNING
									8.1

	ATTITUDES 1.1	1.2	1.3	1.4	1.5	FACTORS 2.1	2.2	2.3	2.4	DEMOGRAPHICS 3.1	3.2	3.3	WELL-BEING 4.1	4.2	4.3
2.3 Use oral communication to give or receive information and directions.	x	x	x				x						x	x	x
3. Students will be able to interpret the implied meanings of information presented in written, oral and visual communcations.															
Students will be able to:															
3.1 Comprehend implied meanings of written, oral and visual communications.	x	x	x	x											
4. Students will be able to evaluate content and use of written, oral, aural and visual communications.															
Students will be able to:															
4.1 Determine the significance and accuracy of information and ideas presented in written, oral, aural and visual communications.	x	x	x	x										x	x
4.2 Use oral communication to influence others and to respond to persuasion.															
4.3 Distinguish and interpret sounds of nature, language, music and environment.															
4.4 Listen, read, view and evaluate presentations of mass media.	x	x	x	x											x
5. Students will be able to generate, organize, express and evaluate ideas in oral and written forms.															
Students will be able to:															
5.1 Use a variety of techniques to generate writing and speaking topics (prewriting*).	x	x	x	x	x								x	x	x
5.2 Organize ideas in understandable format (prewriting and planning).															
5.3 Select appropriate form of writing based on audience and purpose (prewriting and planning).															
5.4 Present ideas in understandable sequence on the topic selected (drafting).															

	4.4	4.5	4.6	4.7	4.8	COMMUNICATION 5.1	5.2	5.3	5.4	5.5	FAMILY 6.1	6.2	6.3	6.4	COMMUNITY 7.1	7.2	7.3	7.4	7.5	7.6	SERVICE 8.1
2.3				x	x	x	x	x	x	x	x	x		x		x		x		x	
3.1									x	x	x	x									
4.1		x	x	x												x		x			
4.2																					
4.3																					
4.4																					
5.1	x	x				x	x	x	x	x			x					x	x	x	x
5.2													x								
5.3																					
5.4																					

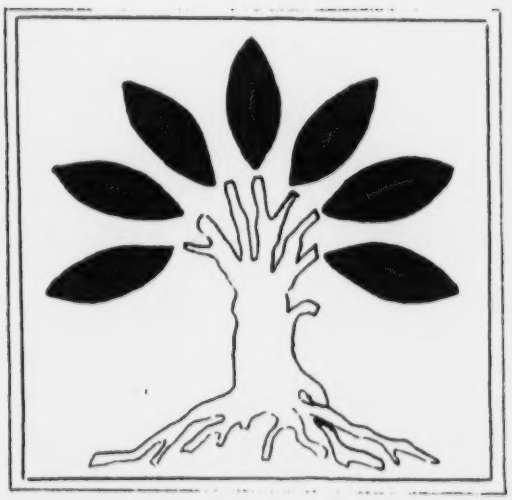
	ATTITUDES 1.1	1.2	1.3	1.4	1.5	FACTORS 2.1	2.2	2.3	2.4	DEMOGRAPHICS 3.1	3.2	3.3	WELL-BEING 4.1	4.2	4.3	●
5.5 Select and use language, gestures and symbols appropriate to audience, purpose, topic and setting when making oral presentations (planning and drafting).																
5.6 Evaluate and revise own writing for meaning, clarity, and comprehensiveness (revising and rewriting).																
5.7 Apply the conventions of writing to produce effective communication (editing and proofreading).																
6. Students will be able to use reasoning skills.																
Students will be able to:																
6.1 Recognize, construct and draw inferences concerning relationships among things and ideas.																
6.2 Generate and test interpretations, explanations, predictions, and hypotheses.																●
6.3 Identify problems and approach their solution in an organized manner.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
6.4 Make reasoned evaluations.	x	x	x	x												
6.5 Formulate and support a position using appropriate information and sound arguement.																
6.6 Reflect upon and improve own reasoning.	x	x	x	x									x	x	x	
7. Students will be able to manage personal habits and attitudes, time and instructional resources constructively in order to accomplish learning tasks.																
Students will be able to:																
7.1 Clarify purposes of assignment.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
7.2 Use resources beyond the classroom.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
7.3 Select and use appropriate study techniques.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
7.4 Practice appropriate and positive health behaviors to enhance learning.																●

	4.4	4.5	4.6	4.7	4.8	COMMUNICATION 5.1	5.2	5.3	5.4	5.5	FAMILY 6.1	6.2	6.3	6.4	COMMUNITY 7.1	7.2	7.3	7.4	7.5	7.6	SERVICE 8.1
5.5																					
5.6																					
5.7													x								
6.1																					
6.2																					
6.3	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x	x
6.4											x	x		x	x	x		x			
6.5																					
6.6	x																				
7.1	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
7.2	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
7.3	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
7.4																					

DEFINITION OF AN ELDER

An Elder is a person who is still growing, still a learner, still with potential and whose life continues to have within it promise for the future. An Elder is still in pursuit of happiness, joy and pleasure, and her or his birthright to these remains intact. Moreover, an Elder is a person who deserves respect and honor and whose work it is to synthesize wisdom from long life experience and formulate this into a legacy for future generations.

(The Live Oak Project)



How To Use This Guide

1. The curriculum concepts and objectives are each numbered. The resource materials for each objective are all indexed with the same number. For example: Concept #1 - Attitudes, Objective 1 - Myths About Aging; looking in the resource section, you will find teaching resource materials for myths numbered 1.1 in upper right corner.

2. Select and emphasize the concepts, objectives and activities that meet or advance the goals of your school curriculum.

3. It is suggested that one start with concept 1 - Attitudes Toward Aging and the Elderly. Since attitudes involve all students, this will help students identify with the gerontology curriculum.

4. If only a few concepts from the curriculum are used, it is suggested these be: Concept 1: Attitudes; Concept 6: Family Relationships; and Concept 5: Communication Skills.

5. Use the guide to stimulate your own ideas and creativity.

CURRICULUM CONCEPTS AND OBJECTIVES

CONCEPT #1: ATTITUDES

Objectives:

1.1 The student will identify and correct common myths about aging and older people.

1.2 The student will analyze media portrayals of aging and identify positive and negative images.

1.3 The student will analyze personal experiences with the elderly to determine the influence of these experiences on attitudes.

1.4 The student will identify his/her own attitudes and examples of ageism in his/her own behavior and in the behavior of others.

1.5 The student will develop an appreciation of the older person's contribution to family, community, and society.

CONCEPT #2: FACTORS AFFECTING AGING

Objectives:

2.1 The student will identify major physiological, biological, and environmental factors which influence aging.

2.2 The student will describe how earlier life experience (cohort effect, roles, historical events, cultural experience) influences aging.

2.3 The student will identify major social/psychological factors which influence an individual's aging.

2.4 The student will identify aging as an interaction of physical, social, and psychological processes which vary greatly from individual to individual.

CONCEPT #3: DEMOGRAPHICS

Objectives:

3.1 The student will define and describe the concepts of "young-old," "old-old."

3.2 The student will describe demographic trends which are resulting in an increasing number of elderly in the population and the changing "young-old," "old-old" composition.

3.3 The student will analyze the impact of demographic trends upon families, communities, and society.

CONCEPT #4: WELL-BEING IN LATER LIFE

Objectives:

4.1 The student will identify the developmental tasks of adulthood and aging.

4.2 The student will analyze the factors that influence how people adapt to the developmental tasks of aging.

4.3 The student will describe the mental health status of older adults and identify major mental health problems.

4.4 The student will recognize that sexuality is an important part of the human experience throughout the life cycle.

4.5 The student will identify the needs of the dying person, his/her loved ones, and how these needs can be met.

4.6 The student will be able to distinguish between normal age-related changes and diseases.

4.7 The student will identify practices that support good health throughout one's life.

4.8 The student will assess the potential long term impact on aging of his/her current health behavior.

CONCEPT #5: COMMUNICATION SKILLS

Objectives:

5.1 The student will describe changes in hearing and vision that may occur with age.

5.2 The student will demonstrate effective skills for interacting with the hearing-impaired.

5.3 The student will analyze living environments to assess their support for the visually impaired.

5.4 The student will demonstrate effective communication skills for interacting with people of all ages.

5.5 The student will describe the role of reminiscence in people's lives.

CONCEPT #6: FAMILY RELATIONSHIPS

Objectives: 6.1 The student will identify factors that affect intergenerational relationships including grandparenting.

6.2 The student will discuss patterns of family interaction in later life and analyze how these patterns change if the family member's health and/or level of independence change.

6.3 The student will develop an appreciation of one's own family and its history and traditions.

6.4 The student will apply a problem-solving process to addressing common situations facing families in later life.

CONCEPT #7: COMMUNITY RESOURCES

Objectives: 7.1 The student will define the continuum of care and identify the specific services that make up that continuum.

7.2 The student will define the concept of functional ability and relate to the concept of continuum of care.

7.3 The student will appreciate the interrelationship of self-care, family care, and community care.

7.4 The student will analyze a community and identify services available to its members including the elderly.

7.5 The student will understand that services exist as a result of the political process and that individuals can bring about change by participating in local, state, and federal government processes.

7.6 The student will identify careers in gerontology and how other careers are influenced by the elderly.

CONCEPT #8: SERVICE-LEARNING

Objectives: 8.1 The student will actively participate in service-learning activities which involve the healthy and the frail elderly.

CONCEPT #1: ATTITUDES

Objective 1.1: The student will identify and correct common myths about aging and older people.

Generalization:

A number of common myths have affected attitudes toward and interactions with the elderly. Myths are often based in half-truths, such as the myth that most older people are in nursing homes and most are lonely and miserable. In fact, at any one time about 5 percent of all persons over age 65 are in nursing homes and 20-25 percent will spend some time in a nursing home. A small percentage of elderly report feeling lonely and miserable most of the time. Exaggerated beyond the facts, myths become the basis for fear and negativism toward aging and the elderly. Research has suggested that persons with more accurate knowledge about aging have more positive attitudes toward aging and the elderly.

Strategies and Resources:

1. Have the students write ten words or phrases that come to mind when they think of old people. Share with the class and discuss which are accurate and which are inaccurate descriptors of aging and old people.

2. Use one of the "Myths and Realities of Aging" questionnaires (resource section 1.1) to identify some common myths about aging that the students believe. Use the answer sheets to discuss each item.

Objective 1.2: The student will analyze media portrayals of aging and identify positive and negative images.

Generalization:

The media, including newspapers, magazines, books, television, films, and music often portray the elderly in manners that are not consistent with the reality of aging. Research indicates that the media demonstrates negative attitudes toward the elderly in three ways: omissions, stereotypes, and distortions. That is, the elderly are often underrepresented in the media and that when the elderly are depicted, they are often portrayed in stereotypic ways as constipated, unhealthy, complaining, forgetful, and/or comic characters.

Nevertheless, some media portrayals reflect more realistic views of the elderly, presenting their capacities and needs. As consumers of the media's messages, we should become conscious of the negative and positive portrayals of the elderly and be aware of the impact of these portrayals on our attitudes toward aging and the aged.

Strategies and Resources:

1. Define positive and negative images of the elderly. Divide the class into small groups for the purpose of gathering data. Each group will be assigned a different media (newspaper, television, advertisements, magazines) from which to gather data. Have the students categorize images they find into positive and negative categories and analyze the media sources that provide each image. Identify occurrences of stereotypes, distortions and omissions.

2. Develop a mural or collage using newspaper, magazine pictures, ads, birthday card slogans, stories, and quotes to depict aging, the elderly, and/or a senior citizen.

3. Have students watch television and analyze the problems the TV families face and how they solve them in relation to stereotyping, relationships, and generational differences. (Some examples of programs are Family Ties, Cosby Show, Webster, Facts of Life, Golden Girls, Kate and Allie, Diff'rent Strokes, and Gimme a Break.) Identify occurrences of stereotypes, distortions and omissions, as well as positive images.

4. Use the "Media Watch" guide in the resource section to analyze media including TV, newspapers, films and magazines, and advertising. Identify occurrences of stereotypes, distortions and omissions.

Objective 1.3: The student will analyze personal experiences with the elderly to determine the influence of these experiences on attitudes.

Generalization:

In addition to the influence of knowledge and media portrayals of the elderly, attitudes toward aging and the aged are influenced by our personal experiences with older persons. Research indicates that both the amount and type of contact with older persons influence attitudes toward aging. Specifically, persons with more contact with older people are likely to have more positive attitudes, particularly if that contact includes a wide range of older persons, not solely the very frail, institutionalized elderly. While contact with the frail elderly is important, this contact should stress the resources and value of these individuals as well as their needs and should emphasize that frailty is only one part of life's experience which does not characterize all older people.

Thus, interaction with a wide range of older people can contribute to both realistic assessments of aging and awareness of the tremendous diversity among the elderly population.

Strategies and Resources:

1. Have students close their eyes and recall an experience with an older person. On a 3 x 5 card write down a positive experience on one side and negative experience on the other. Analyze the impact of these experiences on their attitudes.

2. Have students complete the "Sentence Completion" attitude questionnaire in the resource section. Discuss each question, asking students to identify the persons, or experiences that contributed to that attitude.

Objective 1.4: The student will identify his/her own attitudes and examples of ageism in his/her own behavior and in the behavior of others.

Generalization:

Myths, inaccurate media coverage, and limited interaction with the elderly contribute to ageism. Through ageism the aging process and the elderly are perceived in broad, predominately negative terms. In turn, ageism may contribute to further myths, media inaccuracies, and withdrawal from the elderly. In effect, age stereotyping and ageism ignore the wide range of capabilities, interests, and abilities among the elderly.

Ageism is pervasive and often unconscious. For example, birthday cards that make a joke about being "39 and holding" reflect ageism. Sayings like "you can't teach an old dog new tricks" become critical social issues when they underlie beliefs about older clients' unresponsiveness to advice, services, education or counseling. By becoming aware of overt and covert ageism we can begin a lifelong process of confronting the ageism that limits us as we age.

Strategies and Resources:

1. Have each student complete the sentence completion attitude questionnaire (see resource section). Use the discussion guide at the end of the questionnaire to identify ageism and attitudes.

2. Read the definition of ageism in the attached article on ageism. Use the questions to guide a discussion of ageism. Read and discuss the section of the article on "how to fight ageism."

3. In our society a common insult is to be called "old" or "old-fashioned." It is just as insulting to be called "childish," "juvenile," "adolescent," or "immature." Discuss: Is there a privileged age range, a time when we seldom have to worry about being taken seriously? If so, at what age do we slip into this favored position and at what age do we start to slip out?

4. Develop a display of birthday cards and/or jokes that are examples of ageism.

5. Day 1 - Have each student write a one page description of an 80-year-old person.

   Day 2 - Students are to act according to the previous day's description. Attach to their clothing a brief written description of appropriate dress for an 80-year-old. Discuss reactions.

   Invite a panel of four or five men and women, 80 and over, from the community to join the class for discussion and sharing.

Objective 1.5: The student will develop an appreciation of the older person's contribution to family, community, and society.

Generalization:

Over 60 percent of the elderly are volunteers in some capacity and volunteers make a major contribution to families, churches, and civic and community services. Beside volunteering, many older people still work, provide child care and other services in families, and/or are actively involved in some form of artistic expression, political activities, and other endeavors.

Strategies and Resources:

1. Have a display of "lost arts" (i.e. quilting, tatting, needlework, wood carving, etc.) and have elderly people who practice this art demonstrate to the class.

2. Contact the Retired Seniors Volunteer Program in your community and arrange for a panel of older people to share their experiences with the class. Include people who are involved in a variety of activities.

Concept 1.1

MYTHS AND REALITIES OF AGING

Clara C. Pratt
Oregon State University
May, 1986

Answer each question True or False. Then discuss the correct answer.

T F 1. Aging starts when people are about 30 years old.

T F 2. A substantial proportion of the elderly are in nursing homes.

T F 3. Most people decline intellectually when they get old.

T F 4. Old people feel useless and unneeded.

T F 5. Most older people are ignored by their families.

T F 6. Most older people eventually will be senile.

T F 7. Most older people are not interested in sex.

T F 8. Because of Social Security, Medicare, and other government programs, old people are financially secure.

T F 9. Most men die a couple of years after retirement and most women die a year or two later.

T F 10. Old age is a time of rapid decline in physical capabilities and health.

Answer Sheet to

MYTHS AND REALITIES OF AGING

Many of your beliefs about aging may be based on myths. What are the facts about aging? If you are like most people, even older ones, you may not understand aging very well. Here are some common myths about aging. You probably have heard some of them repeated as truths.

1. Myth: Aging starts when people are about 30.

   You age continuously from the time of conception. The rate at which you age is affected by heredity, physical health, nutrition, mental health, and other unknown factors. Scientists now believe that human beings have a "biological clock" that limits our life span to about 130 years, even if all illnesses and other stresses are removed.

2. Myth: A substantial proportion of the elderly are in nursing homes.

   Only about 5 percent--one in twenty--of the people over age 65 live in nursing homes or other institutions. Like the other 95 percent, chances are you will spend most of your older years living in the community. Further, only 14 percent of the community-living elderly have physical conditions that limit their mobility. Fully 80 percent of the elderly are capable of moving about their communities if adequate transportation is available. So you can look forward to being an active community dweller well into advanced age.

3. Myth: Most people decline intellectually when they get old.

   Barring major illness, you can expect to be alert and active in later life. In fact, older people do as well as or better than younger people on tests of vocabulary, verbal comprehension, and arithmetic. These are skills you use throughout life and they do not fade with age.

   You can learn throughout life. As you age, you may prefer to learn at your own pace and may take somewhat longer to learn than when you were younger. But you can, and should, still learn new things. Like other parts of your body, your brain functions best when it is used regularly. Adult education classes, reading, volunteering, clubs, second careers, political activities--these are just some of the ways you can use and expand you mind throughout your life.

4. Myth: Old people feel useless and unneeded.

   Probably you will not feel useless or unneeded when you are old. Although only about 10 percent of people over 65 work for pay, the great majority have interests that keep them involved and active. Many volunteer in their community and thus provide valuable labor. Others work at personal hobbies and leisure activities in music, art, crafts, politics, and education. In a recent study, 5 percent of people under 65 complained about not feeling needed, while only 7 percent of people over 65 said they felt unneeded. So you can look forward to a change in your activities in retirement, but you can find interests and activities that are valuable to you and others.

5. Myth: Most older people are ignored by their families.

Most older adults do not live with their children. This does not mean, however, that your children will desert you. About 80 percent of older adults have children and live independently, but near at least one child. Contact is frequent and in terms of exchange of family services, both generations give and receive. Most young families cannot afford to support older parents financially, but there are mutual exchanges of work, affection, and concern.

The most comfortable relationships exist in families in which both generations love and yet respect the rights of the other. Older parents need to recognize that adult children have a right to lead their own lives and raise their children in their own way. At the same time, adult children must recognize that their parents are individuals with rights, needs, limitations, and desires that need to be respected. If older people become ill, family members are the most likely source of support and care. This caregiving can best be offered when several family members help and community services are used to supplement family care.

6. Myth: Most older people eventually will be senile.

Most older people will never become senile. Medically speaking, senility is called organic brain syndrome. Its main symptom is disorientation. That is, a person may not know exactly where he is, who he is, or what time it is. If these symptoms appear, a physician should be consulted immediately. Sometimes the cause can be corrected. Only about 2 percent of the people between 60 and 70 have symptoms of organic brain syndrome. While this percentage increases with very old people, only about 6.5 percent of all people over age 60 have symptoms of organic brain syndrome.

7. Myth: Most older people are not interested in sex.

Sexuality is present all through our lives and a sexual relationship can and should have as deep a meaning for older persons as for younger people. Too often, sexual activity for older adults is seen as unnecessary, impossible, or just not "nice." The greatest limits to sexual activity in aging are misinformation and negative stereotypes. Research reveals that human sexual response may be slowed by the aging process but it certainly is not ended. Older persons need and want the affection, warmth, and support that close, loving relationships provide. There is no age limit on our need to love and be loved.

8. Myth: Because of Social Security, Medicare, and other government programs, most old people are financially secure.

Older people are better off than they were in the 1960's and 1970's; however, many are not "well-off." In fact, the 1980 national census showed about half the elderly in Oregon had annual incomes less than $8,000, and half the elderly single individuals had incomes below $4,000. For the most part, the single individuals were widowed women living alone.

Further, government medical insurance paid less than 50 percent of the average older person's medical costs. Older Americans have nearly twice the out-of-pocket medical care expenditures of Americans under 65. Nutrition, transportation, senior center, housekeeper, and home health care

are some of the services that serve seniors. These services, however, reach only a limited number of seniors and must be continued and expanded if older adults are to live comfortably in the community.

9. Myth: Most men die a couple of years after retirement and most women die a year or two later.

You can expect to spend 1/4 to 1/3 of your entire life span in retirement. At 65, average life expectancy is 14 more years for men and 18 more years for women. Because of this difference in male-female life expectancies and the tendency of men to marry women younger than themselves, married women can expect to spend several years as widows. Of course, these averages may not apply to you directly, but they do give a picture of long and potentially active older adult years.

10. Myth: Old age is a time of rapid decline in physical capabilities and health.

As you age, you are more likely to suffer from chronic illness. For most older adults, however, these illnesses are controllable and do not greatly limit activities and interests.

Normal physical changes in hearing and vision begin in your twenties and progress slowly through adulthood. You adapt to these over time and often do not notice any sudden, major change. Furthermore, eyeglasses and increased lighting in homes usually can relieve many of these aging changes. Properly fitted hearing aids and the willingness to learn to use them can help the hard of hearing person.

Proper nutrition, dental care, exercise, and rest, throughout your life, will have a definite impact on your health status as you age. It's never too early or too late to start caring for your health.

Concept 1.1

MYTHS AND REALITIES OF AGING

What Do I Know About People Over 60?

Directions: For each question, circle T for True or F for False.

1. T F In 1980 there were about 36 million Americans over age 60. The number over age 65 was close to 26 million, and increasing at the rate of about 1400 a day.

2. T F One of the fastest-growing segments of the population is the age group 100+.

3. T F In the U.S. as a whole, persons over 65 are more likely to be victims of violent crime than are persons aged 16-19.

4. T F At birth, Canadians rank first in the world, Australians rank second, and Americans rank third, in life expectancy.

5. T F In the U.S., the average length of life of White women is about 77 years; of Black women, about 73. The average length of life of White men is about 70 years; of Black men, about 65. The combined average for American Indian women and men is about 46, and for Hispanic Americans it's about 47.

6. T F Although the overall proportion of the U.S. population over 65 is 11.3%, the figure varies among different segments of the population. Over 12% of Whites are 65+, compared with about 8% of Blacks and about 5% of Hispanics.

7. T F Although menopause is a disease with several distressing symptoms, most women experience only mild symptoms.

8. T F Most symptoms of disease in older adults are not caused by aging at all. They stem from physical inactivity, poor nutrition, and overeating.

9. T F Sexual interest and capacity in old age are affected by exercise and diet.

10. T F Normal physical aging of heart, lungs, and muscles can be slowed, and even reversed, by regular exercise.

11. T F High blood pressure is the main killer of older adult Black Americans.

12. T F More people die of old age now than in the days before sanitation and antibiotics, when more died of contagious diseases.

Reproduced by permission of American Guidance Service, Publishers' Building, Circle Pines, MN 55014. Aging: A New Look by Alexandra Robbin. Copyright 1982. Rights reserved.

13. T F Medicare covers nearly all the medical expenses of U.S. citizens over age 65.

14. T F Thanks to Social Security and pensions, few persons over 65 are poor.

15. T F People who become seriously mentally ill in old age are more likely than other old people to have suffered a severe lack of love in childhood.

16. T F About three-fourths of older Americans have living grandchildren.

17. T F About 10% of people over 65 have children who are also over 65.

18. T F About half of the people 65+ who have living children are members of a four-generation family.

19. T F The method of control used most often by elderly parents with their adult children is screaming and yelling.

20. T F About 80% of Americans 65+ have at least one living brother or sister.

21. T F Older Mexican-Americans are breaking away from the tradition of living with their grown children, but their family ties usually stay very strong.

22. T F American families tend to abandon their older members when the elders' health and income decline.

23. T F Most older men are married, but most older women are widows.

24. T F About two-thirds of all women over 65 live alone.

25. T F It's estimated that close to 10% of older adults are homosexual.

26. T F About 20% of older Americans never attend religious services.

27. T F People over 65 tend to be less interested in politics, and to vote less often, than people in their 20's.

28. T F In 1979, about half of Americans 65+ had a high school diploma.

29. T F In some ways, people are better suited for creative work in old age than they are at a younger age.

30. T F The average person need not worry about a decline in mental ability in the later years.

31. T F Most people who choose to retire do so before the age required for full Social Security benefits.

32. T F Women are more likely than men to fib about their age (to claim they're younger than they are).

ANSWER SHEET

Myths and Realities of Aging
What Do I Know About People Over 60?

1. TRUE Each day, about 4700 people reached age 65 and about 3300 people over 65 died; net increase about 1400.

2. TRUE In the U.S. in 1978, there were about 14,000 people over age 100. In just four years, 1974-78, their number had risen 43%.

3. FALSE LeMar Empey of the University of Southern California analyzed the 1977 national crime-victim surveys of the U.S. Department of Justice. They showed 16-to-19-year-olds the victims of violent crime eight times more often than people over 65 (68 per thousand younger persons, versus 7.5 per thousand older persons). Youths were also more often the victims of theft (150 per thousand younger persons, versus 24 per thousand older persons). Of course, neighborhoods vary.

4. FALSE For females, Canada ranks 6th, the U.S. 7th, and Australia 8th; Switzerland ranks first. For males, Canada ranks 8th, Australia 10th, and the U.S. 11th; Japan ranks first.

5. TRUE The American Association of Retired People (AARP) says this unevenness highlights the unfairness of raising the age for full Social Security benefits above 65.

6. TRUE The difference between percentages of Whites and Blacks over 65 is explained by the shorter average life of Blacks, in turn affected by differences in adequate health care, in turn affected by racial discrimination and lower income. The low percentage of Hispanic elders is explained partly by the high number of young Hispanic immigrants in the total Hispanic population and partly by their shorter average life.

7. FALSE Menopause is not a disease; it's a normal process. Only about 10% of women experience severe distress; about 50% have mild distress; about 40% have no distress at all.

8. TRUE Some would add psychological stress and environmental pollution as contributors to disease at any age.

9. TRUE

10. TRUE But it needs to be some kind of endurance activity, such as cycling, swimming, or brisk walking.

11. TRUE The difference is especially striking in the death rate of Black men aged 45-50, six to seven times the death rate of White men the same age, due mainly to high blood pressure -- which can be controlled. About three-fifths of Blacks, and two-fifths of Whites, over age 65 have definite hypertension.

12. FALSE A trick question. Nobody dies of old age. There is always at least one specific physical cause of death.

Reproduced by permission of American Guidance Service, Publishers' Building, Circle Pines, MN 55014. Aging: A New Look by Alexandra Robbin. Copyright 1982. Rights reserved.

13. FALSE Medicare is said to cover less than 43% of older Americans' medical expenses.

14. FALSE About 12% of Whites, 34% of Blacks, and 23% of Hispanics 65+ live below the official poverty level. And incomes 25% above the official poverty level are still classified as poor. Four out of five Black women 65+ have incomes below that. Hugh Downs, on "Over Easy," reported in 1981 that 45% of women over 65 live in poverty and are not covered by Social Security.

15. TRUE Canadian studies have also shown that old people with dementia have tended to overreact to stress ever since childhood.

16. TRUE

17. TRUE

18. TRUE

19. FALSE It's pouting and withdrawing.

20. TRUE

21. TRUE Despite a trend toward more independent living, family ties are the main source of older Mexican-Americans' feelings of life satisfaction.

22. FALSE When older people need home health care, 80% of it is provided by their families.

23. TRUE In the U.S. in 1979, 77% of older men were married, and 52% of older women were widows. There were 5.3 times as many older widows as there were older widowers.

24. FALSE It's about one-third.

25. TRUE The Kinsey studies of 1948 and 1953 showed 13% of men and 7% of women aged 16-55 to be primarily homosexual in sexual and affectional orientation when both experience and psychological response were taken into account. Orientation is assumed not to change in older adulthood. In 1977, the Institute for Sex Research at Indiana University restudied Kinsey's data from 1938-1963, taking into account only "extensive or more than incidental experience," not psychological response. Those tabulations indicated 13.95% of males and 4.25% of females, for a combined average of 9.13% of the total population.

26. FALSE A 1978 HUD Survey on the Quality of Life, collected by Louis Harris and Associates, showed some 47% of people over age 65 never attend religious services.

27. FALSE A study of three U.S. Presidential elections, 1960-1968, showed that 68% of people over 65 voted, compared with 58% of those aged 21-29.

28. FALSE About half had fewer than 10 years of schooling. About 9% had fewer than 5 years.

29. TRUE Older people have more experiences to draw from, and they commonly have more patience, more ability to take failure in stride, better mastery of the environment, better decision-making skills, and better critical thinking ability than they ever had before.

30. TRUE Many of the studies claiming to show a decline in intelligence have identified the effects of illness, not of old age, says Harry R. Moody, of the Brookdale Center on Aging of Hunter College. He adds, "In some areas, such as tests measuring insight into problem situations, in creative understanding, and metaphoric processing, older people show actual statistical gains."

31. TRUE During the 1970's the American trend was toward early retirement. By 1980, three-fourths of workers retiring voluntarily under Social Security did so before they reached age 65.

32. FALSE "Contrary to popular belief, men are more vain about their age than women," says David Hackett Fischer. "The 'thirty-nine' syndrome is a masculine weakness, not a feminine one. It is also strongest in what we call middle age -- rising through the thirties and forties, peaking at about fifty...but never entirely disappearing." Fischer analyzed the phenomenon of "age heaping" in U.S. Census data. He says it's common for people, especially men, to list themselves on the Census as 39, even until they're suddenly 49.

Concept 1.2

MEDIA WATCH

-- See how the mass media perpetuate ageism.

-- Consider ways to combat ageism in the media.

Johnny Carson, the TV personality, once remarked that some people object to being called senior citizens. There's a better word for them, he said: "O-o-o-l-d!"

That wisecrack wasn't unique. According to Lydia Bragger, a co-founder of the Gray Panthers, Carson's comment and his "Aunt Blabby" character are but two examples of comedy that employs caricatures and laugh lines "cruel to the many older people who depend on television not only for entertainment but for companionship as well. [These jokes] must also strike terror in the hearts of people who are middle-aged."

Bragger lists three main kinds of age bias in the mass media: stereotypes, distortions, and omissions. They're not confined to comedy.

Stereotypes are demeaning simplifications of appearance and personality -- portraying elders, for instance, as moralistic old women or as sex-crazed old men in baggy clothes.

Distortions are exaggerations and incorrect portrayals of aging; for example, showing helplessness, confusion, crankiness, nosiness, stubbornness, slow thinking, or resistance to change as typical of older adults. Another form of distortion is pointing out active, competent older adults as exceptional rather than typical. Another is identifying a person as "elderly" when his or her age is irrelevant; for example, reporting "an elderly clerk was shot" when we wouldn't think of describing the victim as "a middle-aged clerk" or a "brown-haired clerk."

Omissions are the scarcity, and sometimes total lack, of elders as central or romantic characters in stories and advertising, as news and weather broadcasters, as variety show hosts. In television, omissions are evident when young people are hired to do the talking for old people, when young actors are hired to play older characters even though competent older actors are available, and when qualified elders are passed by as writers, directors, producers, narrators, and consultants in putting together the news, programs, and commercials. Another word for omission is invisibility. Racial minorities and disabled people know it well.

A Closer Look At TV

Imagine you're a young person who watches a lot of television. In your home are three TV sets, each with a video recorder that lets you tape any show you miss while you're watching another channel. If you were to arrange to see all the dramatic programs during a week of prime time (8:00p.m.-11:00p.m.) and all the daytime programs over a weekend, what would you learn about aging?

Reproduced by permission of American Guidance Service, Publishers' Building, Circle Pines, MN 55014. Aging: A New Look by Alexandra Robbin. Copyright 1982. Rights reserved.

You'd think very few people reach old age. Of every 100 speaking characters on prime time, you'd see just two or three over age 65. On weekends, the prime viewing time for children, the number would drop to one or two.

You'd think those who do reach senior adulthood tend to become wicked. Although you'd see more "good" people than "bad" people of any age, you'd learn that a higher proportion of older people than younger people are villains. They start to turn bad around 50 -- the age adolescents who watch a lot of TV say people are old.

You'd see men aging slower than women. Among actors whose real ages are 55 to 64, 22% of the men and 33% of the women are cast as older than 65. Of the few actors who really are 65+, 72% of the men and 90% of the women are cast as 65+. There are plenty of younger women for the older men, but no such abundance of younger men for the older women.

You'd notice that men grow more successful with age while women become less so -- that, in fact, older women are more often unsuccessful than successful.

You'd not see older people held in very high esteem. In television programs, about 70% of older men and more than 80% of older women are not held in high regard or treated courteously -- a pattern of treatment very different from that for younger characters. No wonder. Half of the older men and two-thirds of the older women are presented as silly, eccentric, or lacking common sense.

Those numbers were reported in 1980 after a decade of research by The Annenberg School of Communications, University of Pennsylvania. Here are a few of the researchers' conclusions:

> Watching television is not associated with any positive images of older people. The more people -- especially young people -- watch TV, the more they tend to see elders in negative, unfavorable terms. Heavy viewers are more likely to think that people -- especially women -- are old at 50; that older people are a vanishing breed; and that those who do exist are not open-minded and adaptable, not bright and alert, not romantic or active sexually, and not good at getting things done. These beliefs are strongest among those who have little contact with older persons in real life. The investigators said there is no assurance the beliefs will change as viewers grow older themselves and learn more about aging from other sources.

1. The Annenberg study also showed that on television "we under-represent, and in many ways devalue, children and adolescents, as well as old people." Have you noticed misrepresentation of young people on TV? Is this any more or less objectionable than TV's general treatment of older adults?

2. The Annenberg researchers said, "Artistic and dramatic functions require selection, amplification, and intention, all of which may deviate from what the census reports or what independent experience reflects. The important question is not so much whether there are deviations, but what kind exist

and with what consequences for thinking and action."

Do you agree with these statements? Or would you advocate an affirmative-action program within the television industry to show about 11% of the characters as 65+, and to show them realistically? Would you advocate the same requirements for game shows and news broadcasting as you would for dramatic and comedic programs?

3. Imagine you're a TV network executive responsible for choosing money-making dramatic programs. You think that the way to make money is to appeal to the age bracket 25 to 45. What would you do if a coalition of high school students and retired people asked you to show more people their ages and to show them more realistically? What would you tell the coalition? Would you change your program plans? Why, or why not?

4. Can you think of a dramatic series or special program that has given an accurate and well-balanced portrayal of senior adults? Do you know how well it did in the ratings?

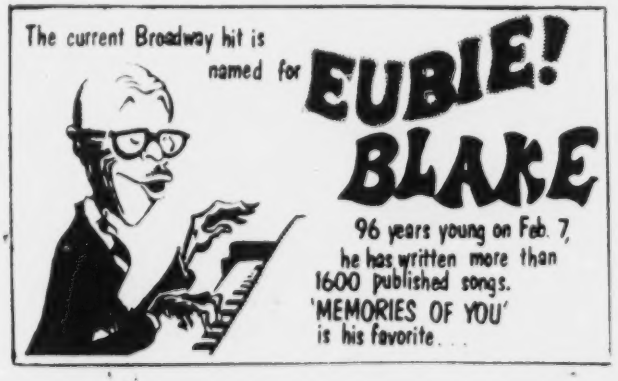
5. What do you think of the researchers' finding that the most negative and mistaken views of older people tend to come from young people who have little contact with senior adults in daily life? What does this say about the way we design our communities and choose where we live?

Examples -- Blatant and Subtle

Here is an assortment of ads, cartoons, newslines, headlines, and comments noted in books and newspapers and on radio, television, and the lecture circuit. Do you agree that all are ageist? Have you noticed any others like them? Is it always clear whether the main bias is ageism or sexism?

Intensive Gardening is something children and senior citizens can do as well as anyone else. (TV spot for Intensive Gardening)

When a high-fashion women's boutique advertises a sexy nightgown, it at least pictures it worn by a model who can wear it -- and not by a 70-year-old grandma. It, thus, at least suggests that this gown is not for every woman. (Financial columnist Sam Shulsky in Investors' Guide)


The current Broadway hit is named for
EUBIE!
BLAKE
96 years young on Feb. 7, he has written more than 1600 published songs.
'MEMORIES OF YOU' is his favorite...

You already know how important it can be not only to think young ... but to stay young! That was one of the avowed objectives of NAMP when it was first founded -- to help its members think and stay young. (Membership renewal notice from The National Association of Mature People)

It's easy for a 15-year-old to give a quick answer. He doesn't have that much to think about. (Newspaper report of Hugh Downs addressing the Metropolitan Senior Federation, Minneapolis)

Are you hoping your family will ignore your birthday this year? (Oil of Olay advertisement)

FOR THESE 'YOUNGSTERS' LIFE BEGINS AT 80 (Headline in Ebony magazine)

During the Late Adult Transition [about age 60 to 65], a man's task is to sustain his youthfulness in a new form appropriate to late adulthood.... As part of the "grandparent" generation within the family, he can at best be modestly helpful to his grown offspring and a source of indulgence and moral support to his grandchildren. (Daniel J. Levinson, et al, in The Seasons of a Man's Life, 1978)

Why advertise your age? Why show the world you're old enough to need bifocals? (Pearle Vision Centers)

Never to grow old is the whole point of growing up. (Sydney Harris, syndicated columnist)

"Staying On," as the title suggests, may indeed be a story of two old crocks fading away after outliving their usefulness to just about everybody except each other, but it is a far more fascinating and richly textured bit of geriatric drama than we're accustomed to seeing on American TV. (Will Jones, Minneapolis Tribune, reviewing British TV production)

It takes a long time to become young. (Picasso at 86, title of book by Garson Kanin)

American Cancer Society poster designed to discourage young people from smoking: SMOKING IS VERY SOPHISTICATED (Picture showing old man with cigarette)

It's fun being an older woman -- when you don't look like one. (Esoterica skin cream)

Dear Ann [Landers]: You know you are getting older when... It feels like the morning after the night before, and you haven't been anywhere... You look forward to a dull evening. You still chase women, but have forgotten why... You try to straighten the wrinkles in your socks and find you aren't wearing any. A little old gray-haired lady tries to help you across the street. She's your wife.
Ann says: Thanks for my laugh for the day. (Ann Landers, Field Newspaper Syndicate)

She doesn't look her age, of course. The only way to really look 100

years old is to be dead. (Joe Rhodes, Minneapolis Tribune staff writer, describing one woman's birthday celebration)

Thank goodness Mom's more careful to use Bufferin now. (Voice of daughter speaking for mother who has arthritis)

Molly Picon, 82, actress: I want to get older without getting old. Frank Blair, host: Good thought! (On TV program "Over Easy")

Even Popeye is getting older. He's eating strained spinach now. (On "The Best of Johnny Carson")

Insomnia is uncommon in children, common in adults, and commonplace in the elderly. (Marilyn Machlowitz, New York Times Service)

Sometimes ageism is combined with prejudice against people with disabilities. Notice the little sign in the corner:

YES... I'D LIKE TO PLACE AN ADVERTISEMENT
PERSONAL
Mature Calif. gent. of secure means seeks acceptable companion for trip to Washington. Must share similar conservative interests and should know what Family means. Mechanical aptitude with handling and maintenance of perambulatory vehicles an advantage. Apply in writing

Copyright 1980, Washington Star. Reprinted with permission of Universal Press Syndicate.

What are the overriding messages of these examples as a whole? What feelings do they prompt in you?

Invisibility

In all media, omission is as harmful as the stereotyping and distortion shown above. How many senior adults, other than a famous actor now and then, do you see in newspapers and magazines promoting "glamour" items? The older men and women you do see are more often selling remedies for physical complaints. At best they are boosting "old-fashioned" foods and beverages or insurance policies for people their own age.

And how many fashion models over 25 appear in department store catalogs, flyers, and Sunday supplements? How many department store manikins have gray hair and mature bodies and faces?

Turning Things Around

We can do something about these rude implications that people of certain ages have little value. We can refuse to buy the products promoted by ageist advertising. We can complain to the stores that sell the products, and to the manufacturers and their national associations. We can offer constructive suggestions. The Gray Panthers recommend, for example, changing phrases like 'younger skin' to 'softer skin' and 'feeling younger' to 'feeling stronger'. We can write and phone TV and radio station managers to request older newscasters, actors, hosts, models, and participants. We can take time to compliment the

media that do include older people, children, and adolescents realistically.

Change may not happen right away, but when enough people take notice of something, you can bet the media -- and the business community -- will take notice too.

Action Plans

1. Avoid products and stores whose advertising says there's something wrong with growing older. Spend your money elsewhere.

2. Keep postcards and radio/TV station phone numbers handy. Use them to comment on programs and commercials that perpetuate stereotypes, distortion, and omission of elders. (Remember that elders of all ethnic groups should be visible, and that physical disabilities are a natural part of life that should not be kept out of sight.) Use the phone and mail also to compliment especially well-balanced and accurate portrayals.

   To make your comments most effective: Identify the title of the program or the sponsor of the commercial. Note the date and the name of the station. Tell exactly why the material offended or pleased you. Note your age, sign your name, and give your address.

   For television, mail comments to the national network office, the local station, and the producer of the show. The producer's name appears in the credits at the end of the program.

   To find owners and addresses of your local radio and television stations, see the TV and Radio Directory, Volume 3 of the reference series Working Press of the Nation. Your city library should have it.

   The receivers will take your comments even more seriously if they see "carbon copy: Gray Panthers Media Watch" at the end. Lydia Bragger is leading the establishment of media monitoring centers in New York, Los Angeles, and other cities.

3. Compute the proportion of older adults you see as models in local department store catalogs, floor displays, fashion shows, newspaper ads, and ads enclosed with monthly statements. For each category, compare the proportion of models with the proportion of people 65+ in the general population: 11% or more (at least one of every nine people). Protest or compliment what you find. If you can, suggest remedies for your complaints.

   Do the same with magazine advertising. Send findings to the director of advertising. Do the same with billboards and other visual media.

   You can find company addresses in national business directories in your library. For association addresses, see the Encyclopedia of Associations. Or phone your librarian.

Concept 1.3, 1.4

SENTENCE COMPLETION

-- Record some of your current thoughts and feelings about age.

-- Begin to identify your attitudes toward aging.

-- Ask yourself which attitudes you'd like to keep and which ones you'd rather change.

One way to get your thoughts out where you can see them is to finish sentences started by someone else. The following unfinished sentences can help you sort out your attitudes toward aging. Record the first response that comes to mind. Be honest with yourself. Keep the answers private, if you wish.

Date _____ , 19 ____

1. When I see young people stay seated on the bus while an old person has to stand, I _____
_____
_____
_____

2. When I see an old person in a swimsuit, I _____
_____
_____
_____

3. When I think about my own old age, I _____
_____
_____
_____

4. If I needed surgery and the doctor scheduled to operate on me was 75 years old, I _____
_____
_____
_____

5. Old women _____
_____
_____
_____

Reproduced by permission of American Guidance Service, Publishers' Building, Circle Pines, MN 55014. Aging: A New Look by Alexandra Robbin. Copyright 1982. Rights reserved.

6. If I enrolled in a local history class and found the instructor to be 18 years old, I _____

7. (Circle one) Most old people find it harder/easier than young people to adapt to change, because _____

8. Apartment owners who refuse to rent to families with children _____

9. Old men _____

10. The best age is _____ because _____

11. If I were a company president with a job opening for an entry-level position, and if a person over age 40 applied, I _____

12. People over 70 who refuse to retire _____

13. If I advertised for a roommate and the only people who answered were 25 years older than I, I _____

14. When I see a very old person driving a car ahead of me, I _____

15. Old women who are widows _____

16. When I see an ad that says "10% Discount for Senior Citizens," I _____

17. When I am alone with a much older person, I _____

18. When a person reaches age 60 or so, sex _____

19. People who go back to school at 65 or older _____

20. When people get older, their health _____

21. Old people who commit crimes _____

22. When I stop my car for a red light and an old person slowly starts crossing the street, I think _____

23. Old people who stage sit-ins and demonstrations to gain attention for their causes _____

24. An example of an ageist* television commercial is the one about _____
_____
_____
_____
_____

25. The best way to respond to an ageist remark is to _____
_____
_____
_____
_____

* Ageist: discriminating against or stereotyping a particular age group.

1. Which sentences were easiest to finish? Which ones were hardest? Did any of them make you uncomfortable? Did any of your answers surprise you?

2. Do you see any single statements -- or any repetitions, habits of thinking -- that give clues to your attitude toward aging? If so, what do they suggest?

3. Do you see any attitudes you hope you can change? Any you especially want to keep?

Alex Comfort, a British physician, has said: "Ageism is the belief that people cease to be people or become people of a distinct and inferior kind by living a specified number of years...it is based on fear, folklore, and the hangups of a few."

1. What do you think of this definition of ageism?

2. How is ageism related to other prejudices like sexism or racism?

3. How does ageism affect you?

Reproduced by permission of American Guidance Service, Publishers' Building, Circle Pines, MN 55014. Aging: A New Look by Alexandra Robbin. Copyright 1982. Rights reserved.

CONCEPT #2: FACTORS AFFECTING AGING

Objective 2.1: The student will identify major physiological, biological, and environmental factors which influence aging.

Generalization:

Physical aging is an extremely variable process differing greatly from individual to individual. Physical aging is normal and not the result of disease, although a person's vulnerability to chronic disease increases across the life span.

Physical aging is influenced by the interaction of five factors:

1. Genetic factors such as the average lifespan of the human species and the lifespan of one's parents.

2. Lifelong lifestyle, including nutrition, exercise, and stress management.

3. Normal age-related physiological changes such as loss of elasticity in tissue and generalized slowing of response.

4. Disease processes, particularly the chronic illnesses of hypertension, heart disease, arthritis, and diabetes, which occur more commonly with age but are not the result of normal aging alone.

5. The physical environment such as stressful work conditions, air and noise pollution, sanitation, and other physical environment factors.

Strategies and Resources:

1. Read and discuss "Is Your Body Older Than You Are: What is your medical age" and "The Good Life: It Can Kill You" from Blue Cross of Oregon. (See resource section, Concept 4).

2. View and discuss the video from the NOVA series "Aging - the Methuselah Syndrome" (contact your Educational Service District for this video).

Objective 2.2: The student will describe how earlier life experience (cohort effect, roles, historical events, cultural experience) influences aging.

Generalization:

Each person is a blend of personal life history and present resources. Life history is one critical factor that influences an individual's aging. Important variables in life history that influence aging include the cohort effect and work and family roles. Both the cohort effect and earlier life roles are influenced by sex and cultural background.

The cohort effect is the effect of the year of birth and all subsequent experiences upon a group of people born within a particular time span (usually about a 10-year span). For example, people born in the early 1900's experienced the Depression years during their young adulthood, and many of their life-long values about work may have been influenced by this experience.

Other important variables in life history which may influence how an individual ages are previous work and family roles. Role changes occur all through life. One moves from student to worker to retiree and from girlfriend to fiancee to wife to widow. How one adapts to late life role transitions is greatly affected by one's previous role, how it was played, and what was valued in that role. For example, research indicates that persons for whom work was personally very meaningful and provided significant peer relationships may have more difficulty with retirement than persons for whom work was primarily a source of income.

The vast majority of older adults successfully adapt to changes in later life. Understanding a person's life history can enable us to understand the kinds of changes that have occured in his/her life and how earlier experiences influence later life.

Strategies and Resources:

1. View a film which depicts an older person in view of his/her entire life cycle. Identify and discuss the impact of life history (objective 2.2), social and psychological factors (objective 2.3), and the interaction of physical, social and psychological functioning (objective 2.4). Films for this purpose would include: Luther Metke, Agueda Martinez, Birds of Watiadora or Art of Age (see resource list).

2. Have students divide a sheet of paper into three columns. At the top of the first column, have them write "Now." At the top of the second column, write "Middle Years." At the top of the third column, write "Over 65 Years." Have students list in the first column all of the activities in which they presently participate. List those activities they think they will continue or begin to participate in during the middle years and later life, in the second and third columns respectively. Have students compare and discuss their lists. How have the lists changed over the life cycle? Why?

Objective 2.3: The student will identify major social/psychological factors which influence an individual's aging.

Generalization:

In addition to life history, an older person's life is greatly influenced by social/psychological factors including social roles and opportunities, social relationships, and personal identity. Like life history, these social relationships are dramatically influenced by one's sex and cultural or ethnic heritage.

Social roles and opportunities also vary significantly between the "young-old" and "old-old," and reflect both social expectations about what is "appropriate" for older persons to engage in and the individual preferences and resources. For example, for many years mandatory retirement limited the availability of work roles for persons over age 65. While mandatory retirement ages have been eliminated (or raised to age 70) from many positions, involvement in work roles is still influenced by social opportunity as well as individual resources and capacity. Work and other social roles are a fundamental part of our personal identity.

What appears to be most critical for the older person's well-being is the opportunity to be involved in activities and relationships which are meaningful to that individual. For many older persons that meaning is found as a volunteer, spouse, grandparent, political advocate, artist or craftsman, and in other roles.

Strategies and Resources:

1. Have students write a personal epitaph at age 80 and discuss how the way they live now is related to the type of person they will become.

2. See additional activities above for objective 2.2.

Objective 2.4: The student will identify aging as an interaction of physical, social, and psychological processes which vary greatly from individual to individual.

Generalization:

At all ages, every individual is influenced by physical, social, and psychological processes. All behavior is the result of the interaction of these processes. For example, how well you perform on an examination is influenced by your physical health, your social environment, (e. g. your social support from friends and your expectations for how much you in your student role should study) and psychological factors (e. g. how much you actually know and your self-confidence).

This idea of interaction between physical, social, and psychological processes creating all behavior is a critical concept in understanding aging. To understand an older person, it is insufficient to describe how old the person is chronologically, or to describe his/her physical health status. You must also understand social factors (such as social roles and opportunities and family and friendship networks) as well as psychological factors (such as identity, self-esteem, and mental health).

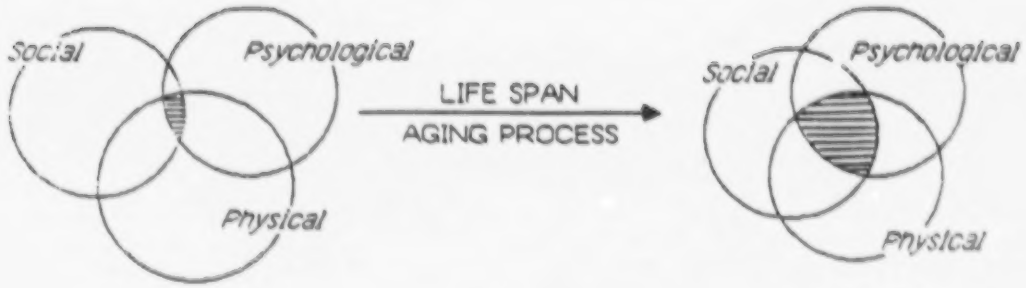
As people age, there is increasing interdependence between the physical-social-and psychological spheres of life. Compared to younger people, older people generally have a greater vulnerability to change, and changes in one sphere are more likely to have an impact on the others more frequently. Thus for the physically frail "old-old" person, a change in housing may result in a period of confusion or a decline in physical health status. The interaction of physical, social, and psychological factors is important to consider in understanding aging and the aged.

Strategies and Resources:

1. View a film which depicts an older person in view of his/her entire life cycle. Identify and discuss the impact of life history (objective 2.2), social and psychological factors (objective 2.3), and the interaction of physical, social and psychological functioning (objective 2.4). Films for this purpose would include: Luther Metke, Aguenda Martinez, Birds of Watadori or The Art of Age (see resource list) , and many others.

2. Have students divide a sheet of paper into three columns. At the top of the first column, have them write "Now." At the top of the second column, write "Middle Years." At the top of the third column, write "Over 65 Years." Have students list in the first column all of the activities in which they presently participate. List those activities they think they will continue or begin to participate in during the middle years and later life, in the second and third columns respectively. Have students compare and discuss their lists. How have the lists changed over the life cycle? Why?

GRAPH



Behavioral Interaction in Adulthood

Behavioral Interaction in Advanced Age

As aging progresses, interaction occurs between the biological-social-psychological domains. Thus, the elderly have a much greater vulnerability to change, and with the more limited physical reserve due to internal aging, changes in any of the domains impact the others more frequently and more directly. For example, a similar bout of influenza in 70-Year-old might precipitate a period of hospitalization or prolonged recovery dependent upon the support of others. This illness could have enormous impact on psychological coping mechanisms while the elder attempts to adjust to the loss of independence. Expectations may be very uncertain for the resumption of social activities, shopping, care of pets, or even continued maintenance of independent living. Similarly, a social change, such as a change in housing may result in a period of confusion or decline in health status, particularly for the frail elderly. The interaction of physical, psychological and social domains is important to consider in treatment of health problems in all age groups, particularly the very old.

DIVERSITY IN SOCIAL AGING

While there is an increase in the interdependence of biological, social and psychological domains and behavior with advancing age, there are wide individual differences among the elderly. In fact, there is evidence that after sixty-five a greater variability exists between individuals. This variability reflects a wide variety of personal experiences and longer life history. Jacques Costeau, internationally known oceanographic scientist, leads a productive and active life shaped by long years of commitment to scientific endeavors and exploration. Indira Ghandi retains a strong political influence as Prime Minister of India, linking the growth and development of her country with her own experiences and that of her father, J. Nehru. Within a local American community, retired farmers, teachers, doctors, mothers, fathers, grandmothers and grandfathers are known chiefly for their roles in society, but also for their contributions to families and work. Their experiences and life histories are the basis for unique individual differences.

Another reason for this diversity is the *cohort effect*. The *cohort effect* is the effect of the year of birth and subsequent socialization upon a group of people all born within a particular time span (usually about 10 years). For example, a *cohort effect* may be seen for all those people born in the United States between 1900 amd 1910. Their childhood was affected by a pre- World War I society, but their young adulthood, early work, and parenting experiences occured during the Depression years of the 1930's. This group of people will retain the *cohort effect* and the impact of socialization from the Depresion throughout their lifes. The influence affects their economic, family, and health care decisions years later, although they have individual personal life histories.

CONCEPT #3: DEMOGRAPHICS

Objective 3.1: The student will define and describe the concepts of "young-old," "old-old."

Generalization:

If we accept the chronological age of 65 as the demarcation line for "elderly," then the age range of elderly persons falls from 65 to over 115. The experiences, needs, and resources of the elderly at the beginning of this 50-year range are dramatically different from those elderly nearing the end. The "young-old" and the "old-old" are descriptive terms that have been used to characterize the elderly at the ends of this 50-year range.

The "young-old" have been called the invisible elderly because they are very similar to late middle-aged persons except for employment status. For the most part, they are usually healthy, active, and adjusting well to retirement. Their family relationships are characterized by patterns of independent living, positive and voluntary interaction, and mutual exchange of assistance such as gifts, child care, and other informal aid.

After age 75, health and income problems become more common. Described as the "old-old," persons over the age of 80 are more likely to have income, social, and health problems that have a negative impact on their ability to meet all of their own needs and to live independently in the community. Thus, as a group, the "old-old" are the major consumers of health and social services provided by both families and communities.

Strategies and Resources:

1. Reproduce and hand out to the class members the visual, "How Old is Old?" and the handout on definitions of age (resource section 3.1). Discuss the importance of recognizing that aging is more than the chronological age. Questions such as the following are good starting points from which to begin:

   a. How old is old? When is a person old? How do you know when a person is growing old?

   b. What makes a person seem old?

   c. How do you decide when someone is old? For example, their wrinkled skin, slow movements, or gray hair? Describe and discuss the diversity of people over age 65.

   d. What do you think it is like to be old? Define the concepts "young-old" and "old-old."

2. Have a "young-old" and an "old-old" person come to class to talk about their daily lives, activities and resources. Relate the characteristics of "young-old" and "old-old" as groups.

Objective 3.2: The student will describe demographic trends which are resulting in an increasing number of elderly in the population and the changing "young-old," "old-old" composition.

Generalization:

The population of persons 65 years old and over has steadily increased from 3.1 million (4% of the total population) in 1900 to 24.5 million (11.2% of the total population) in 1980. By the year 2020, the population of persons over age 65 will exceed 45 million people, over 15.5% of the total U.S. population.

In addition to the overall increase in the population of older adults, the average age of older people is increasing. The fastest growing group of elderly is the "old-old." By 1990 twenty-two percent of the elderly will be over the age of 80. This "aging of the aged" population trend will continue well into the next century.

Strategies and Resources:

1. Have students read and discuss one of the readings on demographic characteristics and trends (see resource section 3.2).

Objective 3.3: The student will analyze the impact of demographic trends upon families, communities, and society.

Generalization:

The increasing population of older adults and the increasing proportion of "old-old" among this population will continue to have dramatic impact upon families, communities, and society. These shifts call for reconsideration of economic and social roles for "young-old" persons, recognizing the resources of this expanding group and allowing more active participation in the labor market and community. At the same time, as a group, the "old-old" are more likely to have needs for family and community support in order to live as independently as possible.

Strategies and Resources:

1. Divide the class into three groups: family, community and society. Brainstorm effects of demographics trends on each of these groups. Report the findings of each group to the class.

HOW OLD IS OLD?

These people continued to work past what we consider retirement age into their seventies, eighties or nineties. All have helped prove that it is the person, not his or her age, who contributes to society.

Oliver Wendell Holmes Jr. was 61 when he began his third career as Associate Justice of the United States Supreme Court. He wrote important decisions shortly before his 90th birthday.

Cervantes wrote Don Quixote at 55.

Benjamin Franklin invented bifocal lenses when he was in his 70's. At the age of 70 he became the first United States Ambassador to France.

Ignace Paderewski, the Polish statesman, didn't start to become a concert pianist until he was in his 50's.

Roman statesman Cato started learning Greek when he was in his 80's.

Ronald Reagan became President of the United States when he was 70 years old.

Grandma Moses began painting in her 70's.

Martha Graham changed dance by fusing ballet with her own style of modern improvisation. She retired from performing at the age of 76 but continued to choreograph and direct the famous Martha Graham Center of Contemporary Dance.

Edward "Duke" Ellington taught himself piano and went on to develop one of Americas most famous jazz styles. At 66 years old he toured the world as a cultural ambassador for the United States State Department. At 71 he was elected to the songwriter's Hall of Fame.

Jack LaLanne was 67 when he swam to Catalina hauling a rowboat full of people.

DEFINITIONS OF AGE

Is age the number of years since birth? There are actually four different definitions or ways to measure age. Measuring the number of years is one interpretation of aging, others describe qualities or abilities.

Chronological Age: the common definition that measures the number of years since birth.

Biological Age: a measurement of life expectancy interpreted as physical capability and appearance.

Social Age: the social role behavior and adjustments to aging expected from peers and society.

Functional Age: a measurement of the adaptive physical and behavioral capabilities of a person, defining the degree to which a person is able to participate within their environment.

It is important to recognize that aging is much more than chronological age, especially when assessing physical and mental health needs. Increasingly, gerontologists are moving to assessing functional age, as opposed to chronological or biological age, as a more accurate indicator of what a person is actually able to do within their environment.

REFERENCES

Butler, Robert W. (1980). "Coming of Age". American Pharmacy, May 20 (5) 9-13.

Hart, Cary S. (1981). The Realities of Aging. Allyn and Bacon, Boston.

A Profile of Older Americans: 1985 was prepared by the Program Resources Department, American Association of Retired Persons (AARP) and the Administration on Aging (AoA), U.S. Department of Health and Human Services.

Information researched and compiled by Donald G. Fowles, AoA.

AARP is the nation's largest and oldest organization of over-50 Americans, retired or not. A nonprofit, nonpartisan organization with over 20 million members, AARP serves its members through legislative representation at both federal and state levels, educational and community service programs and direct membership benefits.

For single copies of this brochure, write:

A Profile of Older Americans: 1985
Department D996
American Association of Retired Persons
1909 K Street, N.W.
Washington, DC 20049

For multiple copies of this brochure, write:

Program Resources Department
American Association of Retired Persons
1909 K Street, N.W.
Washington, DC 20049

AARP

AoA

PF3049(1085) • D996

A PROFILE OF OLDER AMERICANS

1985

The Older Population

■ The older population—persons 65 years or older—numbered 28.0 million in 1984. They represented 11.9% of the U.S. population, about one in every eight Americans. The number of older Americans increased by 2.3 million or 10% since 1980, compared to an increase of 4% for the under-65 population.

■ In 1984, there were 16.7 million older women and 11.3 million older men, or a sex ratio of 148 women for every 100 men. The sex ratio increased with age, ranging from 123 for the 65-69 group to a high of 246 for persons 85 and older.

■ Since 1900, the percentage of Americans 65+ has tripled (4.1% in 1900 to 11.9% in 1984), and the number increased nine times (from 3.1 million to 28.0 million).

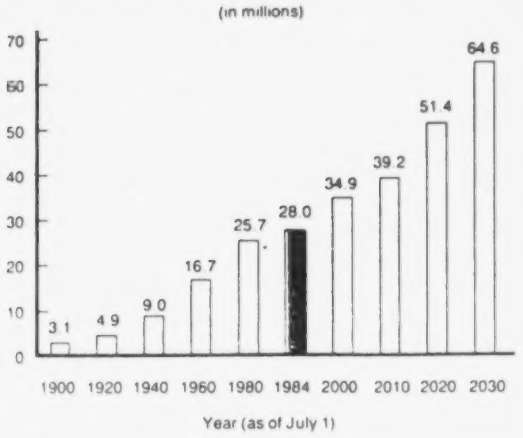
■ The older population itself is getting older. In 1984 the 65-74 age group (16.7 million) was over seven times larger than in 1900, but the 75-84 group (8.6 million) was 11 times larger and the 85+ group (2.7 million) was 21 times larger.

■ In 1984, persons reaching age 65 had an average life expectancy of an additional 16.8 years (18.7 years for females and 14.5 years for males).

■ A child born in 1984 could expect to live 74.7 years, about 27 years longer than a child born in 1900. The major part of this increase occurred because of reduced death rates for children and young adults. Life expectancy at age 65 increased by only 2.4 years between 1900 and 1960, but has increased by 2.5 years since 1960.

■ About 2.0 million persons celebrated their 65th birthday in 1984 (5,500 per day). In the same year, about 1.4 million persons 65 or older died, resulting in a net increase of over 560,000 (1,550 per day).

FIGURE 1
NUMBER OF PERSONS 65+: 1900 to 2030



Note: Increments in years on horizontal scale are uneven.

Based on data from U.S. Bureau of the Census

Future Growth

■ The older population is expected to continue to grow in the future (see fig. 1). This growth will slow somewhat during the 1990's because of the relatively small number of babies born during the Great Depression of the 1930's. The most rapid increase is expected between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

■ By 2030, there will be about 65 million older persons, 2 and one-half times their number in 1980. If current fertility and immigration levels remain stable, the only age groups to experience significant growth in the next century will be those past age 55.

■ By the year 2000, persons 65+ are expected to represent 13.0% of the population, and this percentage may climb to 21.2% by 2030.

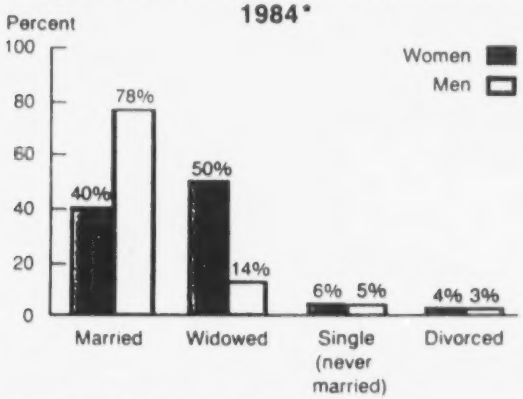
Marital Status

■ In 1984, older men were twice as likely to be married as older women (78% of men, 40% of women).*

■ Half of all older women in 1984 were widows (50%). There were over five times as many widows (7.8 million) as widowers (1.5 million).*

■ Although divorced older persons represented only 4% of all older persons in 1984, their numbers (nearly one million) had increased over three times as fast as the older population as a whole in the preceding 20 years (2.1 times for men, 4.5 times for women).*

FIGURE 2
MARITAL STATUS OF PERSONS 65+: 1984*



Based on data from U.S. Bureau of the Census

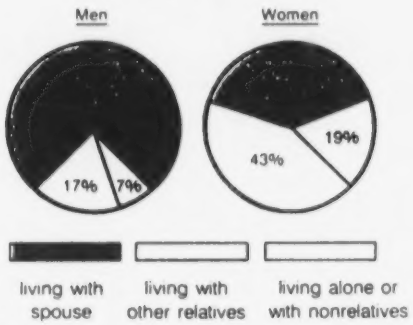
Living Arrangements

■ The majority (67%) of older noninstitutionalized persons lived in a family setting in 1984. Approximately 8.9 million or 83% of older men, and 8.8 million or 57% of older women, lived in families (see fig. 3). The proportion living in a family setting decreased with age. An additional 2% of both men and women, or 625,000 older persons, lived with nonrelatives.*

See footnotes on panel 14

■ About 30% (8.0 million) of all noninstitutionalized older persons in 1984 lived alone (6.4 million women, 1.6 million men). They represented 41% of older women and 15% of older men. Older persons living alone increased in number by 123% between 1964 and 1984, over two and one-half times the growth rate for the older population in general.*

FIGURE 3
LIVING ARRANGEMENTS OF PERSONS 65+: 1984*



Based on data from U.S. Bureau of the Census

■ A 1975 study found that 4 of every 5 older persons have children. Of these, 18% lived in the same household with a child and another 55% lived within 30 minutes of a child. Three-fourths (77%) had seen a child within the previous week.*

■ While a small number (1.3 million) and percentage (5%) of the 65+ population lived in institutions (primarily nursing homes) in 1980, the percentage increased dramatically with age, ranging from 2% for persons 65–74 years to 7% for persons 75–84 years and 23% for persons 85+.

Racial and Ethnic Composition

■ In 1984, about 90% of persons 65+ were White, 8% were Black, and about 1% were other races (including American Indian, Eskimo, Aleut, Asian and Pacific Islander). Persons of Hispanic origin (who may be of any race) represented 4% of the older population.

See footnotes on panel 14

Geographic Distribution

■ In 1984, about half (49%) of persons 65+ lived in eight states. California and New York had over 2 million each, and Florida, Illinois, Michigan, Ohio, Pennsylvania, and Texas each had over 1 million.

■ Persons 65+ constituted 13.0% or more of the total population in twelve states in 1984 (see fig. 4): Florida (17.6%); Arkansas, Rhode Island, Iowa, and Pennsylvania (14.0% to 14.9%); and Missouri, South Dakota, Massachusetts, Nebraska, Kansas, Maine, and West Virginia (13.0% to 13.9%).

■ In eleven states, the 65+ population increased by more than 14.0% between 1980 and 1984 (see fig. 5): Alaska (33%); Nevada (32%); Hawaii (23%); Arizona (22%); Utah and New Mexico (17% each); South Carolina and Idaho (15% each); and Florida, North Carolina, and Washington (14% each).

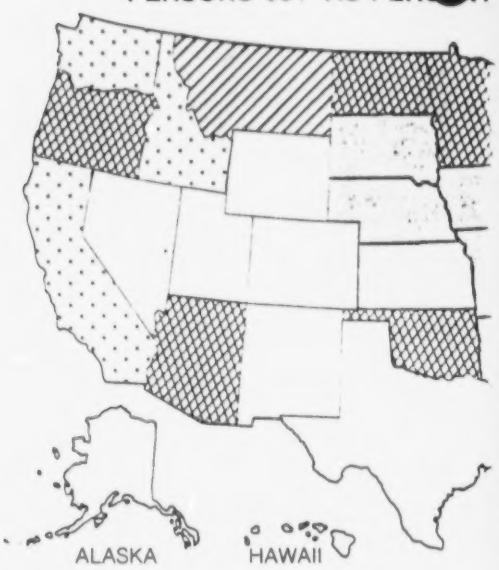
■ Persons 65+ were slightly less likely to live in metropolitan areas in 1980 than younger persons (71% of the elderly, 75% of persons under 65). About 32% of older persons lived in central cities, and 39% lived in suburbs.

■ The elderly are less likely to change residence than other age groups. In 1980, only 23% of persons 65+ had moved since 1975 (compared to 48% of persons under 65). The majority had moved to another home in the same state.

■ In 1980, over 1.1 million persons 65+ had moved to a different state since 1975. Of these, over two-fifths (42%) had moved from the Northeast or Midwest region to the South or West (compared to 27% for younger persons) and one-fourth (25%) had moved to Florida (8% for younger persons).

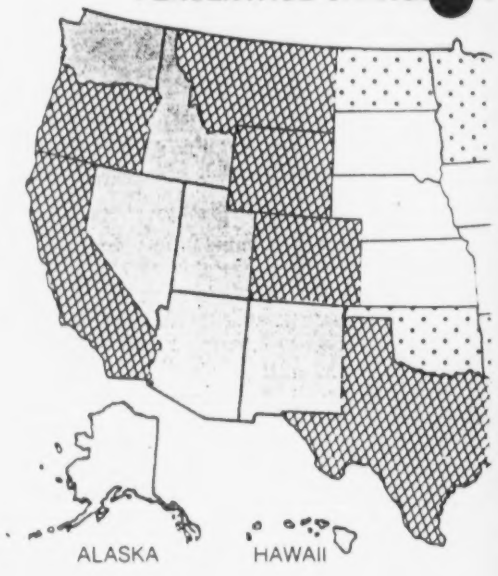
F

PERSONS 65+ AS PER T

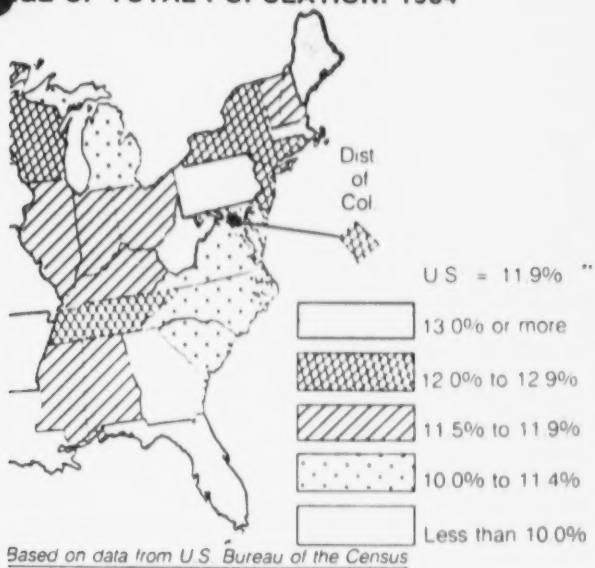


FIC

PERCENTAGE CHANGE E

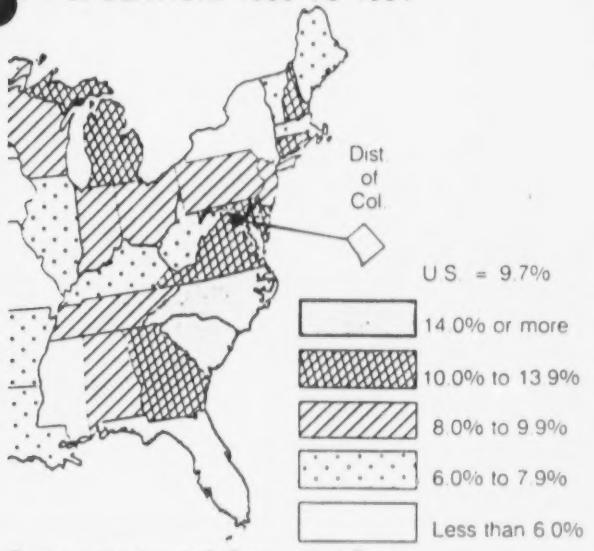


3URE 4
GE OF TOTAL POPULATION: 1984



Based on data from U S Bureau of the Census

URE 5
+ POPULATION: 1980 TO 1984



Based on data from U S Bureau of the Census

FIGURE 6
THE 65+ POPULATION BY STATE: 1984

State	Number (000's) 1984	Percent of all Ages 1984	Percent Increase 1980–84	Percent Below Poverty Level 1979*
U.S., total	28,040	11 9	9 7	14 8
Alabama	476	11 9	8 3	28 4
Alaska	15	3 1	32 6	14 2
Arizona	375	12 3	21 9	12 2
Arkansas	336	14 3	7 4	28 2
California	2,693	10 5	11 5	8 3
Colorado	280	8 8	13 4	12 8
Connecticut	407	12 9	11 6	8 8
Delaware	67	11 0	13 8	13 6
District of Columbia	75	12 1	1 5	18 9
Florida	1,931	17 6	14 4	12 7
Georgia	577	9 9	11 7	25 7
Hawaii	94	9 0	22 9	10 5
Idaho	108	10 8	14 9	16 0
Illinois	1,356	11 8	7 5	11 9
Indiana	638	11 6	8 9	12 7
Iowa	410	14 1	5 9	13 3
Kansas	323	13 3	5 6	14 2
Kentucky	438	11 8	6 8	23 3
Louisiana	435	9 7	7 5	27 7
Maine	152	13 1	7 6	16 4
Maryland	447	10 3	13 0	12 7
Massachusetts	777	13 4	6 9	9 7
Michigan	1,007	11 1	10 3	12 2
Minnesota	517	12 4	7 7	14 8
Mississippi	306	11 8	5 9	34 3
Missouri	682	13 6	5 3	17 4
Montana	96	11 6	13 2	14 4
Nebraska	216	13 4	4 8	15 5
Nevada	87	9 5	32 2	10 7
New Hampshire	114	11 7	10 6	12 3
New Jersey	942	12 5	9 6	9 9
New Mexico	135	9 5	16 6	21 1
New York	2,247	12 7	4 0	11 6
North Carolina	688	11 2	14 1	23 9
North Dakota	87	12 6	7 6	17 0
Ohio	1,280	11 9	9 5	12 6
Oklahoma	401	12 1	6 5	21 0
Oregon	344	12 9	13 4	11 8
Pennsylvania	1,676	14 1	9 5	11 9
Rhode Island	138	14 3	8 7	12 8
South Carolina	331	10 0	15 1	25 4
South Dakota	96	13 6	5 8	20 2
Tennessee	566	12 0	9 4	25 1
Texas	1,514	9 5	10 4	21 2
Utah	128	7 7	16 9	11 8
Vermont	63	11 8	7 8	13 8
Virginia	572	10 2	13 2	17 3
Washington	492	11 3	14 0	11 3
West Virginia	255	13 0	7 1	18 5
Wisconsin	611	12 8	8 4	9 6
Wyoming	42	8 2	12 3	14 0

(Below Poverty Level figures reflect most recent information available)

Based on data from U S Bureau of the Census

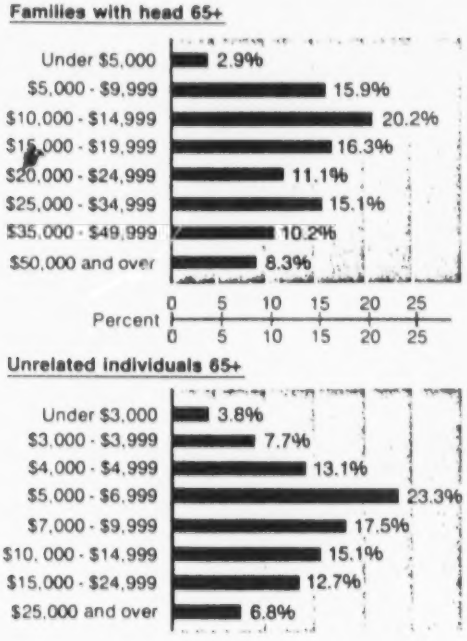
See footnotes on panel 14

Income

■ The median income of older persons in 1984 was $10,450 for males and $6,020 for females. These incomes were each 7.7% higher than in 1983, and represented 3.3% increases in "real" income after adjusting for inflation.*

■ Families headed by persons 65+ reported a median income in 1984 of $18,215 ($18,775 for Whites and $11,983 for Blacks). About one of every five (19%) families with an elderly head had incomes less than $10,000 and 34% had incomes of $25,000 or more (see fig. 7).*

FIGURE 7
PERCENT DISTRIBUTION BY INCOME: 1984*



$18,215 median for families with heads 65+
$7,296 median for unrelated individuals 65+

Based on data from U.S. Bureau of the Census

See footnotes on panel 14

■ Elderly persons living alone or with nonrelatives were likely to have low incomes in 1984, with half (48%) reporting $7,000 or less. One-fourth (25%) had incomes under $5,000, while only 20% had $15,000 or more. The median income in 1984 for these individuals was $7,296 ($7,722 for Whites and $4,876 for Blacks).*

■ The major source of income for older families and individuals in 1983 was Social Security (37%), followed by earnings and asset income (23% each), public and private pensions (15%), and "transfer" payments such as Supplemental Security, unemployment, and veterans' payments (2%).*

■ Older households were more likely than younger households to have one or more members covered by Medicaid in 1983 (13% vs. 9%), but less likely to have received food stamps (7% vs. 9%). About one-fourth (23%) of older renter households lived in publicly owned or subsidized housing (9% for younger renters).*

■ The median net worth (difference between assets and liabilities) of older households, including those 65–74 years old ($50,150) and 75+ years ($35,950), was well above the U.S. average ($24,600) in 1983. Net worth was below $5,000 for 18% of older households but was above $250,000 for 13%.

Poverty

■ About 3.3 million elderly persons were below the poverty level** in 1984. The poverty rate for persons 65+ was 12.4%, less than the rate for persons under 65 (14.7%). Another 2.4 million or 9% of the elderly were classified as "near-poor" (income between the poverty level and 125% of this level). In total, over one-fifth (21%) of the older population were poor or near-poor in 1984.*

■ One of every nine (11%) elderly Whites was poor in 1984, compared to about one-third (32%) of elderly Blacks and about one-fifth (21%) of elderly Hispanics.*

See footnotes on panel 14

■ Older women had a higher poverty rate (15%) than older men in 1984 (9%). Likewise, older persons living alone or with nonrelatives were more likely to be poor (24%) than were older persons living in families (7%).*

■ The nine states with the highest poverty rates for older persons in 1979 were all in the South (see fig. 6): Mississippi (34%); Alabama, Arkansas, and Louisiana (28% each); Georgia (26%); South Carolina and Tennessee (25% each); North Carolina (24%); and Kentucky (23%).*

Housing

■ Of the 17.9 million households headed by older persons in 1984, 75% were owners and 25% were renters. Older male householders were more likely to be owners (83%) than were females (67%).*

■ The housing of older Americans is generally older and less adequate than the balance of the nation's housing. About 36% of homes owned by older persons in 1983 were built prior to 1940 (21% for younger owners) and 8% were classified as inadequate (6% for younger owners).*

■ The percentage of income spent on housing (excluding maintenance and repair) in 1983 was higher for older households than for younger households among homeowners without a mortgage (15% vs. 10%), homeowners with a mortgage (24% vs. 20%), and renters (32% vs. 28%).*

■ In 1983, the median value of homes owned by older persons was $48,800 ($33,100 for Blacks and $46,200 for Hispanics). About 83% of older homeowners in 1983 owned their homes free and clear.*

Employment

■ About 11% or 2.9 million older Americans were in the labor force (working or actively seeking work) in 1984, including 1.8 million men and 1.2 million women. They constituted 3% of the U.S. labor force. About 3% of these were unemployed.*

See footnotes on panel 14

■ Labor force participation of older men has decreased steadily, from about 2 of 3 older men in 1900 to 1 of 6 (16%) in 1984. The participation rate for older females rose slightly from 1 in 12 in 1900 to 1 in 10 during the 1950's, but dropped to 1 in 13 (8%) in 1984.*

■ Approximately half (52%) of the workers over 65 in 1984 were employed only part-time: 46% of men and 61% of women.*

■ About 750,000 or 27% of older workers in 1984 were self-employed, compared to 8% for younger workers. Three-fourths of these were men.*

Education

■ The educational level of the older population has been steadily increasing. Between 1970 and 1984, their median level of education increased from 8.7 years to 11.4 years (11.0 years for males, 11.6 years for females), and the percentage who had completed high school rose from 28% to 48%. About 9% in 1984 had 4 or more years of college.*

■ The median number of years of school completed varied considerably by race and ethnic origin among older persons in 1984: 12.0 years for Whites, 7.9 years for Blacks, and 6.5 years for Hispanics.*

Health and Health Care

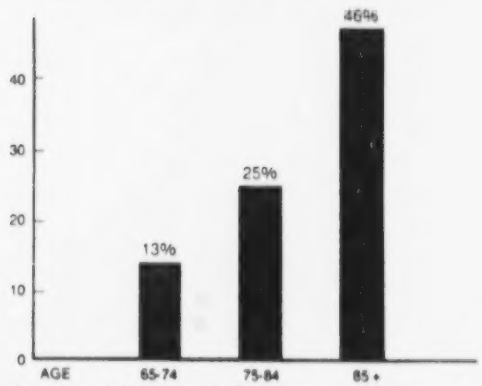
■ In 1982, 35% of older persons assessed their health as fair or poor (compared to 9% for persons under 65). There was little difference between the sexes on this measure, but older Blacks were more likely to rate their health as fair or poor (55%) than were older Whites (33%).*

■ The number of days in which usual activities are restricted because of illness or injury increases with age. Older persons averaged 32 such days in 1982 (27 days for males and 35 days for females, 12 days for younger persons) and spent all or most of 15 of these days in bed (13 days for males, 16 days for females, 5 days for younger persons).*

See footnotes on panel 14

■ The need for functional assistance also increases sharply with age (see fig. 8). In 1982, about 4.8 million older persons living in the community needed the assistance of another person to perform one or more selected personal care or home management activities. This figure represented 19% of noninstitutionalized older persons (16% of males, 21% of females), but the percentage ranged from 13% for persons 65-74 to 25% for persons 75-84 and 46% for persons 85+ (41% of males, 48% of females). (Selected personal care activities included bathing, dressing, eating, using the toilet, getting in or out of a bed or chair, walking or going outside. Selected home management activities included preparing meals, shopping, routine chores, using a telephone, taking medicine, or managing money. Persons were classified as needing assistance if they needed help from another person to do one or more of these activities, or could not do one or more of them at all.)*

FIGURE 8
PERCENT NEEDING FUNCTIONAL ASSISTANCE, BY AGE: 1982*



Based on data from U.S. Department of Health and Human Services prepared by Duke University

■ Most older persons have at least one chronic condition and many have multiple conditions. The most frequently occurring conditions for the elderly in 1982 were: arthritis (50%), hypertension (39%), hearing impairments (30%), heart conditions (26%), orthopedic impairments (17%), cataracts and sinusitis (15% each), visual impairments (10%), and diabetes (9%).*

See footnotes on panel 14

■ About 20% of older persons were hospitalized during 1982 compared to 9% of persons under 65. Among those hospitalized, the elderly were more likely than younger persons to have more than one hospital stay per year (27% vs. 17%) and to stay in the hospital longer (10 days vs. 7 days). Older persons also averaged more visits to doctors in 1982 than did persons under 65 (8 visits vs. 5 visits).*

■ In 1984 the 65+ group represented 12% of the U.S. population but was projected to account for 31% of total personal health care expenditures. These expenditures were expected to total $120 billion and to average $4,202 per year for each older person, more than 3 times the $1,300 spent for younger persons. About $1,000 or one-fourth of the average expenditure was expected to come from direct ("out-of-pocket") payments by or for older persons.

■ Hospital expenses were projected to account for the largest share (45%) of health expenditures for older persons in 1984, followed by physicians and nursing home care (21% each).

■ Benefits from government programs, including Medicare ($59 billion), Medicaid ($15 billion), and others ($7 billion), were projected to cover about two-thirds (67%) of the health expenditures of older persons in 1984, compared to only 31% for persons under 65.

Footnotes:

* Numbers or percentages in paragraphs and figures followed by this symbol refer to the noninstitutionalized population only.

** By the official 1984 definition of $6,282 for an older couple household or $4,979 for an older individual living alone.

DEMOGRAPHIC CHARACTERISTICS

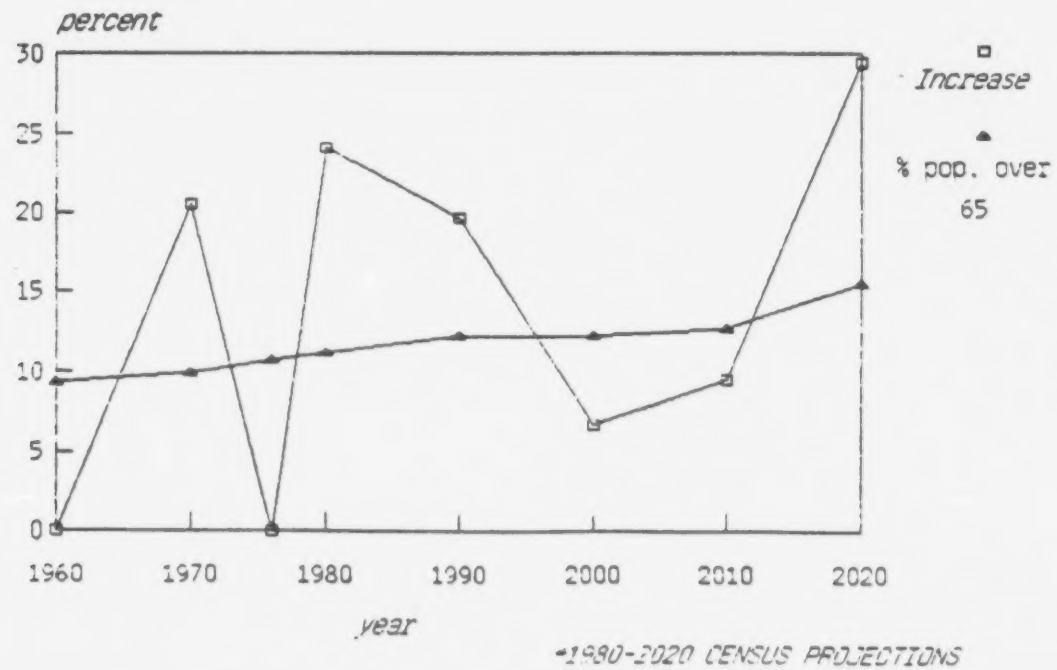
Growth of 65+ Population

Demographic characteristics define the size and composition of a population. The population 65 years of age or older has been steadily increasing since 1900. Approximately 3.1 million men and women were sixty -five or older at the turn of the century. By 1980 the total aged population had reached approximately 24.5 million, or 11.2 percent of the total population.

By the year 2010 the elderly population will exceed 34 million people or 12.7 percent of the total population. By 2020 that figure will have increased to 45 million, representing 15.5 percent of the population of the United States. (Kart, 1981).

TABLE I

ABSOLUTE AND PROPORTIONAL INCREASES IN POPULATION 65 AND OLDER: 1960 -2020



From: Vorce-West, T., Pratt, C., and Associates. Geriatric Pharmacy Practice: A Guide for Clinical Practice. O.S.U., Corvallis, OR, 1985.

The Increasing Elderly Population

One reason for the increasing elderly population is the decline in infant mortality that occured early in this century. In 1900 forty-eight percent of males and fifty-seven percent of females survived the first year of life. By 1970, the proportion of children surviving infancy had dramatically increased; seventy-one percent of the male children and seventy-four percent of the female children lived past the first year.

Immigration patterns have also been a major factor in the growth of the elderly population. Because the vast majority of these immigrants were young adults of child-bearing age, the fertility/birth rates were correspondingly high, contributing to the marked increase in the number of elders sixty and seventy years later. Expected future growth trends also reflect better control of certain diseases, such as coronary heart disease processes that shorten life for middle aged and older adults.

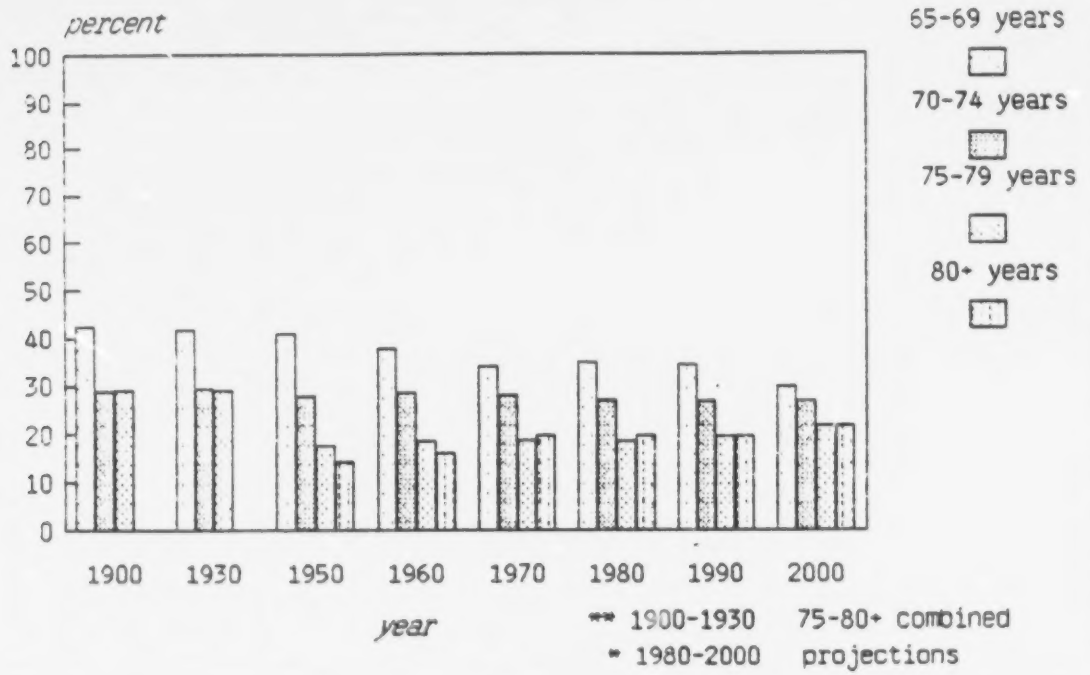
SOCIO-ECONOMIC CHARACTERISTICS OF THE ELDERLY POPULATION

"Young-old" versus "Old-Old"

As the numbers of the elderly population have grown the structure of the population has changed. Three descriptive definitions of elderly age groups have evolved to describe this change: the *Young-Old* (ages 65-74), the *Middle-Old* (ages 75-84), and the *Old-Old* (ages 85 and older).

TABLE II

PERCENT DISTRIBUTION OF POPULATION 65+ YEARS OF AGE: 1900-2000



Specific characteristics are found within these elderly age groups. The *Young-Old* have been called the *Invisible-Elderly* because they are very similar to middle-aged persons except for employment status.. They are usually healthy and active and adjusting well to retirement. Among the *Young-Old* the female to male ratio is 130/100. The *Middle-Old* show increases in problems with income and health, as well as increases in the numbers of females and widows. The *Old-Old* are the major consumers of social and health care services. The female to male ratio among the *Old-Old* is 175/100). The fastest growing population of elderly are the *Old-Old*. By 1990, twenty-two percent of all elderly will be over the age of eighty. This aging of the elderly population is predicted to have a dramatic impact on social and health services.

Economic Status

The likelihood of being poor increases dramatically for the very old, females, or minorities. Approximately eleven percent of the elderly have incomes below the poverty line, of those sixty-five percent are women. However, while eleven percent live below the official poverty line, an additional twenty percent are classified as *near poor*. *Near poor* includes those individuals with incomes within 130% of the poverty line.

Increasing age often brings increases in personal economic dependency, as well as changes in expenditure patterns and income resources. The elderly spend a greater percent of their total income for food, shelter and medical care. The main income sources for most older citizens include social security benefits, public health insurance, and private pension plans.

Health Care Expenditures

Patterns of national health care expenditures reflect the growth of an increasingly elderly population. Currently thirty-three percent of all hospital services and forty percent of physicians services go to meet the health care needs of the elderly. The elderly are consuming twenty-five percent of all prescription drugs. Forty percent need drugs for activities of daily living (ADL). Projections for 2020 estimate that pressure for both ambulatory care and self-care will increase the need for drug therapy, particularly for chronic conditions (American Pharmacy, May 1980).

Living Arrangements

The majority of the those over sixty-five years of age live independently, and a large proportion maintain their own households. However, the living arrangements for men and women differ. While most elderly men live with their spouse, elderly women are more than twice as likely to be widowed and to live alone. Living arrangements also reflect economic resources. Those elderly residing with relatives, other than their spouse, generally have significantly lower incomes. In addition, physical illness or disability and increasing age are other important factors that determine whether an elderly

person continues to maintain an independent household.

Educational Status

The length of formal educational experience has been growing during the twentieth century. However, for those currently sixty-five to seventy-five years of age, the average formal educational level is eighth grade. For those currently older than seventy-five, that average is even lower. This implies that pharmacy education materials need to make drug information simple and understandable, assuming that the elderly consumer's reading level will be around the eighth grade level.

A GENERATION AT RISK

When the baby boomers reach Golden Pond

Robert N. Butler

Robert N. Butler is chairman of the Ritter Department of Geriatrics and Adult Development at The Mount Sinai School of Medicine in New York City. He is the former director of the National Institute on Aging and author of the influential book, Why Survive? Being Old in America *(Harper & Row, 1975).*

The time is now to build into our personal and corporate behavior the realities of a long life ending not in the 60s and 70s but in the 80s and 90s. More and more of us are reaching these years. This is where some revolutionary trends of modern life are taking us as predecessors, successors and members of the baby-boom generation.

We are relatively unprepared. Yes, we do worry about pensions and Social Security income and the costs of Medicare. Only beginning to sting are long-term care expenses and associated taxes affecting corporate, government, individual and family budgets. These costs are harbingers of a complex future that we must begin to plan for systematically, starting now.

The 20th century has seen average life expectancy in this country move from under 50 to over 70. Our society has become incredibly efficient at bringing children into maturity. Today's infant has a 50–50 chance of living more than the biblical three score and 10.

Converging with this expansion of average life expectancy is a second great trend: the aging of that enormous cohort of 76.4 million persons born in the 1946–1964 period. This baby-boom cohort will continue to stress our institutions: the schools were among the first to feel their impact, then the job market; next will be pension plans, Social Security, medical and social care, and other institutions concerned with later life.

The baby boomers constitute a generation at risk. The critical years of their retirement will start about 2010. By 2030, there will be over 50 million retirees, twice today's 65-and-over population. Where 1 in 9 Americans are elderly today, the ratio a half century hence may be 1 in 5, assuming that fertility stays at about the replacement level.

If baby boomers have fewer children per family than their predecessors, this expectation will have profound socioeconomic consequences. The ratio of Americans of typical working age to Americans 65-and-over will reach 2 to 1 as baby-boom retirements increase, considerably under today's 3 to 1. However, the total number of dependents—under 18 and over 65—per 100 working-age Americans will actually be fewer in 2030 than in 1970 or 1960. (See table on page 42.) Presumably, workers will spend less on children and will have more for the elderly.

I disagree with warnings that generational conflict will occur when younger workers are forced to support ever growing numbers of elderly. Not only does this line of argument ignore the decline projected in children per household, which will reduce the overall dependency costs of the baby boomers, it overlooks as well the income transfers that go on from elders to the young.

According to A.J. Jaffe in *The New York Statistician* for November–December 1982, the total dependency ratio in today's population is about 1 to 1, and in 2050 "about half of the total population will still be supporting the other half. . . . The change in the dependency burden is the shift from more younger to more older persons." Jaffe believes that the cost of raising and educating the child population about equals total retirement benefits. "It is evading the issue, if not outright misuse of statistics, only to compare the working force and the over 65," he says.

"A Generation at Risk," Robert N. Butler, *Across the Board*, July/August 1983, pp. 37-45. Reprinted by permission.

Reprinted with permission from The Conference Board and R.N. Butler

One of the most divisive measures for meeting costs of dependency would be government-enforced "filial responsibility"—that is, requiring children to help support their elderly parents. The Reagan Administration has announced a regulatory change in the Medicaid program to allow states to recover, when possible, nursing-home expenses from the children of poor patients. Experience with such policies has shown that they are administrative nightmares. Even when effective, they may result in family disruption, as resources are withdrawn from support of younger members of a family and given to older members. We have no need for coercive and disruptive measures in a society that can meet old-age needs humanely and efficiently with private or social insurance. Moreover, "filial responsibility" cannot help the 1 in 4 nursing-home patients who have no family.

On a scale no other birth cohort has confronted, the baby boomers will confront a double challenge. First, as they approach and enter retirement, they will have to balance their own needs with those of parents and even grandparents. This is illustrated by the 68-year-old daughter who oversees the care, at home or in an institution, of an 87-year-old mother while dealing with her own need for chronic care and that of her 72-year-old husband on a slender retirement income.

Second, as the baby boomers reach the oldest ages, they will have fewer family members to turn to for the same kind of help they gave in earlier years. Not only are more people living to the ages of highest sickness rates but family structure is changing: fewer children, more divorce, and more social isolation, especially because of widowhood. Given the continued emphasis on mobility and living independently, the elders of tomorrow may have to turn to strangers, particularly paid employees of social-service and health-care organizations.

This double challenge will grow rapidly as the population of the most frail elders increases: now one third of all elders, they will comprise 40 percent in only 10 years. The challenge will spread faster among older women, blacks, and Hispanics, since these groups of elderly are growing faster than the total 65-and-over population. For older women, the challenge will be particularly intense; they outlive men and typically are the mainstays of long-term care within the family.

The age distribution of the U.S. population seems to me to be far less a matter for concern than is the future of the economy. Whatever economic complications the baby boom causes for itself through low fertility could be compensated for by a more productive economy, one that utilizes the able elderly. Excluding them from roles in wealth production would represent an immense failure of heart and imagination. The longevity revolution will test our economy's capacity to use the added labor potential.

To minimize dependency and maximize productivity, our society will have to spur institutional change. Age discrimination (as I wrote in these pages in November 1980) serves to maximize dependency and minimize productivity among the elderly. In our personal and corporate lives, we must continue to break down barriers of myth and prejudice.

We will need organized approaches through government and the private sector to improve income maintenance and support systems. This means well-directed investment in biomedical, sociobehavioral and productivity-related gerontological research. We must originate, refine, and routinize programs to help preserve (and recover) health and productivity at any phase of the adult life cycle. Surely this is one of the best ways to reduce the dependency costs of the generation at risk.

Extending the Work Span

How shall we finance the added years of life? Assuming a life span of 85 years, we can imagine the working portion as about half, counting 20 years for retirement and 25 for maturation and education. A 40-year work span could easily accommodate two or more careers.

We could add to savings by extending the work span—by delaying retirement, by taking less leisure time during the working years, and banking the income, and by investing more in public and private pension programs. A delayed-retirement strategy implies a full-employment economy. Will our society have jobs for everyone as the baby boomers move toward old age? If we are evolving into a society that needs fewer people in the conventional work force, how will individuals build up reserves for retirement? Will automation drastically alter the education-work-retirement proportions of the life span?

These questions must be answered if we are serious about reducing risks for the baby-boom generation and its children. Likewise, we must ask hard questions about the solidity and efficiency of retirement-income programs, including Social Security, private pensions, and individual retirement accounts. Major evaluations should be made of the use of tax breaks to encourage people to plan for their own retirement. Should the goal be to encourage those who can to save more, allowing income to escape Federal taxation? Or should the goal be to assure an adequate basic income in retirement for all (for example, through higher Social Security benefits based on higher taxes and more income transferring)? Do we need a better balance between these goals than now exists?

Unfortunately, planning for population aging tends to occur in relatively narrow contexts, in response to perceived institutional crises. The recent deliberations of the National Commission on Social Security Reform extended gingerly into some of the issues of health and productivity. But the approach was to shore up the Social Security financing, and this necessarily

limited the explorations. Nonetheless, the Commission's recommendations offer an entrée into some of the practical issues of planning for population aging.

The bipartisan panel dealt with short- and long-range problems. A deficit of somewhere between $150 billion and $200 billion in Social Security revenue was projected for the 1983–89 period. The panel recommended that this could be made up by a combination of taxes and benefit cuts. Some of these proposed actions would also reduce deficits expected after 2020, when the baby-boom retirees would reach a peak. However, an unresolved issue was how to meet fully the long-range gap.

Republican appointees on the Commission endorsed a gradual rise in the age of full entitlement, or indexing of that age to improvements in average life expectancy. They argued that postponing the age to 68 would be sufficient to keep the program sound through the mid-21st century.

Democratic appointees called the proposed age change a benefit cut for young workers confronting higher taxes over the proposed longer period until retirement. Such a step was unnecessary now, they argued, since the long-range deficit might well be made up through economic growth or additional tax increases.

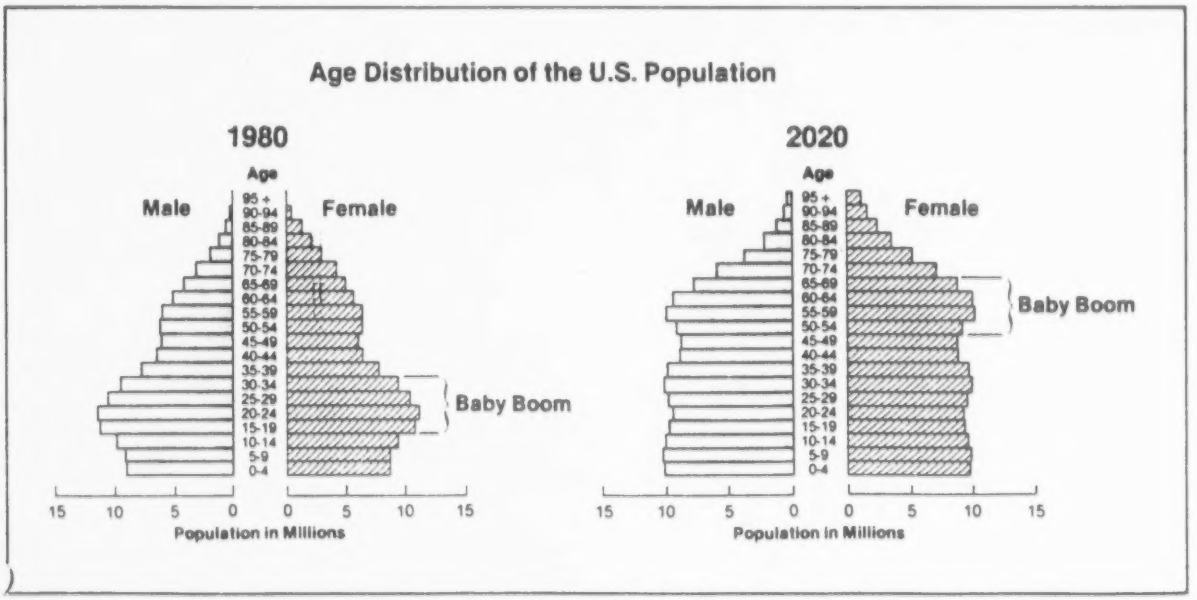
The consensus recommendation of the Commission, however, omitted any call for an age change and instead advocated a policy of encouraging retirement age 66, 67, or 68 by raising benefits by 8 percent for each year of delay. Congress was divided on the issue, and in the end prescribed a gradual rise to age 67 by the early 21st century. This provision is in the law signed by President Reagan.

Neither the Commission nor Congress directly raised the question of whether the United States spends enough on its Social Security program. Other advanced countries—with proportions of elderly the U.S. has yet to experience—seem able to manage a greater investment. Some devote twice the proportion of gross national product to benefits comparable to those offered under our Social Security system.

A major intent of proposals to raise the full benefits age is clear: each year of delay means the individual will put more money into the system and will take less out of it. Attempts to assure the system's soundness are praiseworthy, but we must consider some implications. Will jobs be available? Will they be open to older workers? Will employers or the government be willing to retrain them? Will they be healthy enough and willing to work? Or will they see delayed retirement as an unprofitable trade of healthy years for sick years?

Corporations in various fields have demonstrated ways of keeping older workers on the job, encouraging their re-entry into the work force, and developing part-time arrangements to meet retirees' needs for supplementary cash, as well as their own needs for their skills and for flexible scheduling. *Young Programs for Older Workers*, published by Work in America Institute in 1980, provides case studies of such programs.

Wm. Wrigley Jr. Company has a long-standing practice of phased retirement for employees at age 65: The first year the employee takes a month off without pay, the second year, two months, and the third year, three months. For each year he works from age 65 to 70, the employee adds 8 percent to his base pension; $100 of pension income at age 65 thus becomes $147 at age 70. The term phased retirement, or flexible



The size of the baby-boom generation in 1980, and the projected size in 2020, compared with the rest of the population. The ratio of working-age Americans to those 65+ will decline to 2.1 as baby-boom retirements increase, considerably under today's 3.1. (Source: The Social Security Administration)

retirement, describes any program that allows the employee to gradually change the proportion of leisure time to work time, whether in the form of shorter days, shorter weeks, or months off.

There are various other arrangements to accommodate older workers. IBM fosters second careers to help individuals adjust to technologic and business changes and, when retirement is imminent, to develop new interests and skills. Tektronix Inc. employs a medical placement specialist to redesign jobs for better efficiency and improved job satisfaction on the part of workers who have physical limitations. A carpenter with a back injury can still saw and use the lathe but can't bend to trim moldings; that part of his job is eliminated, and instead he is given part of another job, say, driving a truck and delivering supplies. The Toro Company has a program that uses part-timers in two ways: some do regular part-time work and others are on call for overload periods.

Surveys show that many retirees want to work, that many workers in their 50s intend to extend their working careers, and that business recognition of older-worker productivity is increasing. Employment agencies for older workers have developed to serve these parties. In Los Angeles, a Second Careers Program—a nonprofit organization administered by the Los Angeles Voluntary Action Center—has been assisting companies since 1975 to begin or enlarge pre-retirement and retirement programs and to identify opportunities for volunteer and paid second-career jobs. Mature Temps, formed by the Colonial Penn Group, provides jobs for people over age 50 through 14 offices around the country.

A lot more has to be done to provide options in employment and retirement for older workers. Robert W. Feagles, senior vice president of The Travelers Insurance Company, which two years ago eliminated mandatory retirement, points out that our society has built a system allowing more people to enjoy retirement but, at the same time, limits choices for older people. "In reality," he says, "most people over 65, whatever they may wish to do, face two stark alternatives: either full-time work or full-time retirement, with few options in between." Most private pension systems define retirement so strictly that even a short interval of paid work threatens loss of benefits. Social Security is a prime example of the earnings test.

We have to differentiate the expectations and conditions of tomorrow's older workers from those of today and yesterday. The fact is that two thirds of Social Security retirements occur before age 65. These individuals have actuarially reduced monthly benefits for the rest of their lives. Some early retirements are for reasons of health. Some of these persons are disabled but do not qualify for disability insurance and, through it, Medicare coverage. The disability definition of Social Security has been criticized as unduly severe: an individual must be unable to perform in any job no matter where it is in the nation; older workers cannot be expected to move thousands of miles just to find a job they are able to do. (The commissioners who proposed a change in the full benefits age also suggested provisions to assist sick early retirees, this group confronts reduced benefits at a time of above-average sickness costs—and no eligibility for Medicare until age 65.)

The One-Hoss-Shay Issue

The Commission also considered the notion that people should be able to have longer work lives because improvements in longevity have been accompanied by improvements in health. In June 1982, as director of the National Institute on Aging, I discussed the point at the panel's request, along with Dr. Jacob Feldman of the National Center for Health Statistics.

The Commission wanted comments on a hypothesis set forth by Dr. James Fries of Stanford University that the natural limit of the human life span is about 85 years. Fries's policy-relevant point is that the period of morbidity in later life is shortening; people are likely to stay healthy longer, deteriorating much like the "one hoss shay" in the poem, almost all at once. If true, the trend might provide support for raising the Social Security full-benefit age beyond 65. In addition, the hypothesis offers the comforting prospect of mod-

Younger and Older Dependents

Year	Number under 18 per 100 aged 18–64	Number 65+ per 100 aged 18–64	Total
1930	58.9	9.1	68.0
1940	48.9	11.0	59.9
1950	51.0	13.4	64.4
1960	65.1	16.8	81.9
1970	61.4	17.7	79.1
1980	47.2	18.6	65.8
1990	43.5	20.0	63.5
2000	43.2	19.9	63.1
2010	39.2	20.2	59.4
2020	41.2	26.0	67.2
2030	42.0	31.8	73.8
2040	41.2	30.6	71.8
2050	41.7	30.2	71.9

Projections of the numbers of "dependents" in the U.S. population, young and old (derived from U.S. Census figures by Herman B. Brotman, a consulting gerontologist). The table shows that while the proportion of those over 65 will steadily increase, the relative numbers of those under 18 is generally decreasing. Thus, the total "burden" on the working-age population of both young and old would not be unreasonable. In fact, the proportion of dependents may have been higher in 1960 and [illegible]

eration in the spiraling costs of Medicare and Medicaid as sickness diminishes in late life.

Trend data from the National Health Interview Surdo not support the Fries hypothesis. Sickness and disability rates by age bracket appear to have held steady over the last decade. Conceivably, this could change. However, applying current rates to the growing elderly population, we project a heavier load of sickness and disability in the 21st century.

Policymakers cannot reasonably ignore this projection, even though some anecdotal evidence suggests that the elders of today are in better health than their forebears. Some surely are. But some reach old age already sick, their lives preserved by medical care. Some live to the oldest ages despite great handicaps. And some maintain good health almost to the very end of life. How this mixed picture relates to ability to work is not precisely clear, since we lack objective criteria for assessing various physical and psychological factors in relation to different kinds of work.

This issue was made most clear to me when the National Institute on Aging, at Congressional behest, reviewed the Federal requirement for mandatory retirement of commercial airline pilots at age 60. Was it medically justified? This was hard to say, since there were no conclusive data on whether pilots were more or less like the general population, in which cardiovascular and other morbidity and mortality rates rise sharply in the 60s. Modern airliners are better staffed and powered than those of 1959 when the rule was imposed. But no one could say definitely that a fine record of passenger safety would be maintained. Undoubtedly, some pilots are mandatorily retired with unnecessary loss of their productivity.

The pilot issue is a special case. But it illustrates the shortcomings of our knowledge of aging and disease processes in relation to practical decisions important in population aging. Based on trends, our best guess is that the proportions of the population with disabilities will stay about the same. For the age bracket 65 to 74, which includes the years relevant to the benefits-age issue, the proportion with a limitation on activity due to a chronic illness or disability is projected to be about the same in 2020 as in 1980: about 35 percent. However, the number will double in that period to 10.7 million, reflecting the baby boom.

The activity limitations—joint stiffness, visual and hearing impairment, cardiovascular problems, and other handicaps—need not be so serious as to prevent employment. Policies could be adopted to promote employment of such people. The working day or week could be adjusted. Work environments and tasks might be modified. For instance, in regard to pilots, a report prepared for the National Institute on Aging states: "Research on human factor engineering suggests that alterations in cockpit and equipment design can be made that will take into account decrements in performance, so that small changes in physical capability will not significantly affect a pilot's ability to fly safely."

Ways of making such changes for all kinds of jobs are being, and surely will be, researched and tested. The willingness of public and private sectors to pay their fair share for the accommodations would be an important issue. We are already seeing controversy between government and corporate interests over the recent law requiring job-based health insurance to supplant Medicare as the primary coverage for older workers. The companies oppose the law since private insurance costs more for older workers than for younger workers.

But we must also plan for persons with serious functional limitations who require considerable social support, including medical, hospital, nursing home, and at-home services. We must keep in mind that this group constitutes a sizable minority, but a minority nonetheless, of the elderly population. At any one time, only 1 person in 20 of the general elderly population is in a nursing home; the proportion after age 80 is 1 in 5. This is an important point in considering needs for both institutional and community-based services. According to some estimates, a population double the 1.3 million nursing-home residents is in need of long-term care services in the community. If true, the market for major long-term care services is probably about 4 million of the nation's 26 million elderly.

Because mortality and sickness rates accelerate markedly after age 75, the size of this population has implications for the development of health and social services. It is growing fast — over 9 million today, probably 14 million by 2000. The fastest growing segment of the entire U.S. population is the group aged 85 and older. In 1980, there were 2.6 million, or 1.1 percent of the U.S. population at this age. In 2020, there will be 7.6 million, or 2.5 percent.

Between 1980 and 2020, the 75-and-over population with activity limitations due to chronic conditions will increase 2.5 times, to 10.7 million. The number of short-stay hospitalizations will rise to 104.6 million days from 45.8 million. Instead of 1.1 million in nursing homes, there will be 2.7 million. The number of physician visits will double. Personal expenditure for health care will more than double for the aged, while it rises by 50 percent for the entire U.S. population. Nursing-home expenditures will be in the forefront.

The Geriatrics Gap

Geriatric researchers seek ways to prevent a slow decline in various body systems and to help the patient adjust to changed conditions. They also study a variety of special problems of the elderly. The reactions of the older person to drugs, infection, pain, heart attacks, and other conditions may be different from the reac-

tions of younger adults. For example, mental confusion, not chest pain, may be symptomatic of a heart attack in the older person. So-called senility, or senile dementia, may be reversible once the cause of confusion and memory loss is traced to a treatable cause, such as infection, malnutrition, alcoholism, drug abuse, or depression. Geriatric practice must be concerned with educating patients and families on the true nature of illness in old age, lest misconceptions like "it's just old age" delay treatment beyond the time when it can be most effective.

Unfortunately, the field of geriatrics is underdeveloped in this country. Scientific research into the processes of aging did not expand until recently, and some new conclusions are beginning to appear. Several studies have been done that show far less deterioration in information-processing and problem-solving abilities than investigators in the 1930s had thought.

Some of the most significant conclusions from recent gerontologic research are cautionary. First, what sometimes looks like psychological deterioration due to aging may in fact be more the result of a poor socioeconomic background or little education. For example, a 60-year-old born in 1910 may have greater ability than a 60-year-old born in 1880 simply because he has had a better education.

The enactment of Medicare in 1965 was not accompanied by major investments in research, manpower for service and for research, or by the organization and funding of geriatric services. Medicare was, and is, a benefit package based on what young adults need. It emphasizes short-term or acute care.

The Medicare nursing-home benefit, called "extended care" at first, was basically for convalescence after hospitalization. Because costs could not be forecast reliably, Congress omitted long-term care from the Medicare law. Administrative definitions of reimbursable illness costs exclude coverage of what is disparagingly called "custodial services," some of which are essential to the survival or functioning of patients who are not likely to get "better." For want of home care and other mundane assistance, sound geriatric principles cannot be applied, and some patients become expensive institutional cases.

The only large-scale program of long-term care benefits is found in Medicaid, the Federally aided program of state benefits for the poor. Medicaid money accounts for about half the annual $22 billion spent on nursing-home care. (The other half comes directly from patients or families.) The program's growth is threatening many state treasuries. Unless costs can be moderated, taxes will increase and the increases will cut into profits and wages. This is one reason why some forward-looking business groups are examining long-term care issues and their responsibilities for assisting in resolving them.

Private insurance has eschewed coverage of nursing-home and homemaker services. Reimbursement arrangements under conventional health insurance policies are ill suited to geriatric practice. Only grudgingly do they recognize time spent hearing out, examining, and counseling a patient, or the use of experts in medicine, nursing, and social work as a diagnostic and treatment team. The team approach, a cornerstone of geriatrics, disintegrates at the billing office and dies at the bank. A breakthrough in insurance coverage, through private or public approaches, or a combination of them, is sorely needed.

In addition, we will have to somehow meet the demand for more geriatric physicians—a prospect that now seems unlikely since only a small number of the nation's 127 medical schools have professors of geriatrics or required courses in geriatrics.

Organizing for Productive Aging

How may we organize our thinking for action in the interests of today's elderly and the generation at risk? Plans under way at the Mount Sinai Medical Center in New York City may provide one model.

In 1982, the Medical Center established the nation's first medical school department of geriatrics. The Gerald and May Ellen Ritter Foundation funded the department and the Brookdale Foundation supported the chair in geriatrics that I occupy. The department has six faculty members and eight postgraduate fellows. Wholehearted support by the trustees and administration assured substantial room for mandatory instruction in geriatrics in a crowded medical curriculum. A biomedical research program was authorized. Plans for inpatient and outpatient services for geriatric patients and their families were completed. In addition to providing the community with home care and a wellness clinic, the department is creating a geriatric assessment and referral unit to assist physicians, patients, and families in defining and carrying out programs of care. Special clinics will be devoted to patients with senile dementia, menopausal problems, incontinence, and mobility limitations.

Students and medical residents will be exposed to the well and ill elderly in the community at the hospital and at the Jewish Home and Hospital for Aged. The latter, a nationally recognized long-term care institution, will become a teaching nursing home—a counterpart of the teaching hospital.

To conduct policy-related research and analysis and to raise public and professional awareness of population aging, the department is creating an Institute for Studies of Health and Aging. Applying a broad conception of health, the Institute plans to organize these divisions as funds become available:

☐ The Center for Productive Aging, to study and offer consultation services on issues involved in enhancing the contributions of the older population to

the economy and to family and civic life. The center will advise on such topics as: personnel policies and programs for long-term health and productivity; objective criteria for personal and corporate decisions on work and retirement, and adaptation of the elderly to work tasks and environments.

☐ The Center for Long-Term Care Systems, to focus particularly on long-term care insurance. The center will provide advice and information to corporations, labor unions, health-care organizations, senior citizen groups, and others concerned about long-term care and geriatrics.

☐ The Leadership Forum on Population Aging, to air the issues of population aging in seminars and other formats of practical use to public and private decision-makers. An Aging Information Service will serve the public and mass media as well as private clients.

☐ The Center for International Aging Studies, to bring policy specialists and social and health-care professionals together to examine population-aging issues of international significance. A program of regular exchange between U.S. and foreign teachers and practitioners is contemplated to accelerate the diffusion of geriatric knowledge and skills.

☐ The National Reference Center on Geriatric Education, to promote the development of geriatric training by collecting and disseminating innovative curricula and teaching materials and by advising schools on how to get started.

With well-conceived policies, later life will be a time of options. Even if impaired in some way, we will have opportunities to be productive; we will maintain our vigor for as long as possible, and we will not easily lose our personal autonomy. Supportive programs will exist, staffed by perceptive and humane practitioners, paid for by some contributory method that protects us against impoverishment and affirms our dignity. We will be proud of these accomplishments and leave them to our children. They will say we knew how to age well.

CONCEPT #4: WELL-BEING IN LATER LIFE

Objective 4.1: The student will identify the developmental tasks of adulthood and aging.

Generalization:

Developmental tasks are challenges to be mastered by individuals at different points in their lives. Some developmental tasks are universal (such as young women adjusting to sexual maturity and middle-aged women adjusting to menopause). Other tasks are highly variable. For example, when (or if) one enters or leaves the work force varies greatly from culture to culture and may be strongly influenced by sex and economic status within a culture.

Developmental tasks give us one way of understanding the challenges facing us as we age. The developmental tasks of late life include adjusting to decreasing physical strength and health, adjusting to retirement and reduced income, and establishing satisfying social activities.

The successful accomplishment of developmental tasks will vary greatly from person to person. For example, one person may face the challenge of retirement by extensive traveling, another by active volunteering, and a third by joining the Peace Corps. Whatever the specific adjustment, successful accomplishment of developmental tasks is characterized by a sense of life satisfaction and well-being.

Strategies and Resources:

1. Use the resource sheet on developmental tasks to identify tasks that may be faced by people of various ages. Identify which of these tasks are universal and which vary by sex, culture, income level, or other characteristics. Along the time line for life course stages indicate when the following stages occur: young adult, adult, middle age, mature age and old age. Identify the educational possibilities on the educational time line. As you consider the occupational development of an individual, indicate on the time line where the following events might occur: job aspirations, decisions on preparation, first job, career entry, job plateau, retirement planning and retirement occurrence. Below the occupational development time line, indicate how this could be different for a married female who has children. On the time line for family relations, indicate where marriage might occur, parenthood begin, childrearing end, grandparenthood begin, possibility of widowhood occur, the responsibility for aging parents and finally where being dependent on children might occur. Discuss how these events would be different for males and females, for a single adult, for the poor versus middle class and how it might change for different cultural backgrounds.

2. Have students write a paper, "What I will be doing 20, 30, 40 or 50 years from today." Have them consider health, career, money, leisure activities and relationships with family and friends.

3. Review Erik Erikson's Eight Stages of Development and discuss with students the concept of development as a continuous process throughout the life cycle.

Objective 4.2: The student will analyze the factors that influence how people adapt to the developmental tasks of aging.

Generalization:

Many factors influence how people adapt to the developmental tasks of aging. Life history, social networks, social opportunities, physical health, cultural group experiences, income level, and self-concept are some important factors.

These same factors even influence the specific task faced by an individual. That is, a woman who never married does not face the task of adjusting to widowhood. By recognizing the factors that influence the developmental tasks that we face as we age, we can appreciate the uniqueness and diversity of older persons.

Strategies and Resources:

1. View the film, "Three Grandmothers." Discuss how people in different cultures adjust to widowhood.

2. See one of the films, "Aging" or "The Art of Age." Discuss the developmental tasks faced by each person and the influence of life history and other factors upon the tasks and their resolutions.

3. Have students identify prominent older individuals in the areas of government and politics, public service, the entertainment industry, the local community, their churches and other organizations who continue to lead active, productive lives. Have students analyze and chart their contributions into various sub-headings and identify factors that have influenced how these people have adapted to the tasks of aging.

Objective 4.3: The student will describe the mental health status of older adults and identify major mental health problems.

Generalization:

It is a common belief that many older people are unhappy and suffer from major mental health problems in later life. In fact, most (over 85%) of the elderly do not suffer from significant mental health problems. They adjust well to the challenges and developmental tasks of aging.

For those older persons who do have mental health problems, depression is the most common. Depression is often precipitated by losses of loved ones or physical health. Depression in later life can be very successfully treated with medication, counseling, and/or other therapies.

Some older persons suffer from organic brain syndrome, which is characterized by severe memory loss and disorientation. Many organic brain syndromes are reversible and are caused by drug interactions or other health problems. Severe memory loss and disorientation should not be disregarded as "normal aging," but rather should prompt immediate examination to establish the cause. Some organic brain syndromes are irreversible because there has been permanent damage to brain cells. Alzheimer's Disease is the most frequent cause of irreversible brain syndromes. While Alzheimer's Disease is considered irreversible, patients can be helped to function. Most Alzheimer's Disease patients are cared for by family members and these family caregivers need the active support of other family members, friends, and community services.

Strategies and Resources:

1. Have each student list several characteristics of a mentally healthy individual. Have each student write one of their characteristics on a piece of butcher paper. Give each student three colored stickers and have them place one of their stickers in front of the three characteristics they feel are the most important. Discuss, "Do older individuals have these characteristics?"

Objective 4.4: The student will recognize that sexuality is an important part of the human experience throughout the life cycle.

Generalization:

The importance of sexuality does not decrease with advancing years. Research indicates that seventy percent of older men and fifty percent of older women are sexually active. For women, the best predictor of continued sexual activity in later life is the availability of a healthy, sexually active husband and a life history of sexual interest and activity. For men, the best predictor of continued sexual activity are their life history of activity and their own good health. Even for older persons who are not sexually active, touching, closeness, and a sense of being masculine or feminine continue to be significant parts of sexuality as they have been throughout life.

Strategies and Resources:

1. Use the Oregon State University Extension Service Game, "Sex and Aging: A Game of Awareness and Interaction." The teacher should review all cards in this game to determine which would be appropriate for the particular student group. Use the game instruction sheet to lead a discussion. (See resource section for ordering information).

2. View "George and Juliet," a 30 minute videocassette interview about sexuality with a couple in their 70's. Discuss the importance of sexuality in their lives. (See resource section for ordering information).

3. Read and discuss "In the Middle Years: Sexual Fulfillment" (EC 1020) and publications on "Sexuality and Aging" (SP54-038) both attached. (Order information in resource section).

Objective 4.5: The student will identify the needs of the dying person, his/her loved ones, and how these needs can be met.

Generalization:

Death is as natural a part of life as birth. Because of medical advances, more and more people are living into their 70's and 80's and thus death is increasingly associated with advanced age. Whenever death comes, the dying person and his/her loved ones face one of life's most difficult times. The dying person has three critical needs: 1) the need to control pain and discomfort; 2) the need for love, affection, and touching; and 3) the need for dignity, participation in decisions, and self-worth. Elisabeth Kubler-Ross, a pioneer in the study of the dying, has stated that death with dignity means supporting a person to die "in character" as he/she has lived.

Families facing the death of a loved one and bereavement have needs, too. Foremost among these are the need for time and support to grieve in their own way. How a person dies or grieves may reflect many factors, including age, sex, culture and ethnicity, religion, and the circumstances of the death.

Hospice programs are medical programs designed to meet the physical, emotional, social, and spiritual needs of the dying and their families. The family focus of hospice and the belief that death is a natural part of life are fundamental to the hospice philosophy of care. Hospice programs and sensitive friends and relatives can help to support dying persons and their families.

Strategies and Resources:

1. Read and discuss PNW 88 Extension Bulletin, "Death: A Family Crisis" (in resource section). Identify the needs of the dying and bereaved. Brainstorm and list ways each student could meet some of these needs. Use the attached handout on interacting with the seriously ill and compare its suggestions to the student's ideas.

2. Use the activities and discussion points from the Oregon State University Extension Service Leader-Teacher Guide, "When Death Comes: Understanding Grief" (see resource section).

3. Invite a speaker from a local hospice or other organization that works with bereaved individuals (e. g. Bright Wings, Eugene; Dougie Center, Portland) to discuss their work and the bereavement process. Have students read and discuss the article on Hospice (attached) to prepare for the speaker.

4. References:
   a) "Is There A Right Way To Die?" Psychology Today, October 1978, page 122.
   b) "Preparing A Child For A Good-bye Visit to a Dying Loved One," Journal of the American Medical Association, May 14, 1982, page 2571.

Objective 4.6: The student will be able to distinguish between normal age-related changes and diseases.

Generalization:

Normal age-related changes occur in every system. Physical aging affects our appearance, energy, body, and susceptibility to disease. While the process of physical aging is inevitable, physical disability is not. In fact, most people grow old without ever experiencing significant disability.

It is important to distinguish between normal physical aging and the chronic diseases which are common in later life. Many of these diseases can be prevented, or, if they occur, can be effectively treated before they lead to disability. While aging and disease are two different processes, they are related. The process of aging does lead to increased vulnerability to certain diseases, particularly the chronic diseases of diabetes, hypertension, and heart disease. However, the development of these diseases is also often related to lifestyle, including diet, exercise, and stress management.

Strategies and Resources:

1. Have students list all the physical changes they think of when they think of aging. Define normal age-related changes as having these characteristics:
   a. universal (happens to all)
   b. changes that arise from within the individual
   c. changes that occur gradually
   d. changes that result in increased vulnerability to disease

   Use these characteristics to identify which items on the students' lists are normal age-related changes and which are diseases.

Objective 4.7: The student will identify practices that support good health throughout one's life.

Generalization:

While the basic causes of physical aging are still unknown, it is clear that lifelong high-quality medical care and healthy lifestyles can decrease the incidence of disease and disability throughout one's life. Of particular importance are diet, exercise, stress management, and preventive health care (including regular screenings for disease), and active treatment for diseases which do develop.

Strategies and Resources:

1. Have students read and discuss the booklet, "The Good Life--It Can Kill You" (published by Blue Cross. Order from Blue Cross of Oregon, P.O. Box 1271, Portland, Oregon 97207. Phone: 503-225-5221).

2. Have students use the computer program, Health Maintenance, Volumes 1 and 2, "Well-Being in Later Life" developed by the Minnesota Educational Computer Consortium (Oregon Educational Computer Consortium; 700 Pringle Parkway SE, Salem, OR 97310) to determine how their current health practices will affect their long term well-being.

Objective 4.8: The student will assess the potential long-term impact on aging of his/her current health behavior.

Generalization:

At any age, each person is responsible for his/her own health. Disease and disability in mid-and later life are dramatically affected by a lifetime of personal health habits. By being aware of the potential future impact of current health behavior, individuals are free to make positive, responsible choices.

Strategies and Resources:

1. Have students use the computer program, Health Maintenance, Volumes 1 and 2, "Well-Being in Later Life", to determine how their current health practices will affect their long term well-being (see resource list).

2. Have students use the publications, "The Good Life: It Can Kill You" or "Is Your Body Older Than You Are: What Is Your Medical Age?" (published by Blue Cross. Order from Blue Cross of Oregon, P.O. Box 1271, Portland, Oregon 97207; phone 503-225-5221) to assess the potential impact of their current health behavior.

Developmental Tasks Throughout the Life Cycle

A developmental task arises at a certain period in the life of an individual because of the combined influence of physical maturation and cultural pressure. Successful achievement of the task at the appropriate time leads to happiness and to success with later tasks; failure leads to unhappiness for the individual, disapproval by the society, and difficulty with later tasks.

Chronological Age	10	20	30	40	50	60	70	80	90	100
Life Course Stages										
Educational Development										
Occupational Development										
Development of Family Relations										

Emotional Illnesses

Since the older person frequently experiences many distressing situations—loss of self-esteem, loss of independence, loss of loved ones, fear of physical and mental decline, and fear of helplessness and abandonment—at a time when he has fewer resources for coping with them, his vulnerability to emotional problems is increased.

Two prevalent emotional disorders are anxiety and depression. While they can occur at any age, the stresses and pressures of adjusting to the unique problems of growing older make the elderly especially vulnerable to them.

Anxiety occurs when a person is faced with more stress than he can deal with. While a certain amount of anxiety is natural and unavoidable, it becomes a problem when it is inappropriate or out of proportion to a situation or when it interferes with normal activities. Signs that excessive anxiety may be present in the older person include:

- irritability and tension
- insomnia
- demanding attitude
- loss of appetite
- restlessness
- frequent headaches or other vague physical complaints
- unwarranted concern about a physical ailment

Depression is most often demonstrated by a sense of low spirits or actual sadness although the person may deny both. Other symptoms may include:

- loss of appetite and/or weight
- withdrawal from the company of others
- lack of energy and motivation
- forgetfulness
- poor concentration
- sleep disturbance, especially waking early
- physical complaints, such as headaches, constipation, nausea
- anger, irritability
- feelings of worthlessness and/or thoughts of self-destruction
- feelings of abandonment
- neglect of personal appearance and home

Severe anxiety and depression can usually be treated with special medications, and/or counseling. However, if neglected they can develop into severely disabling conditions. In addition, while the symptoms described may indicate emotional problems, it is of great importance to note that each of them may also be related to an unsuspected physical illness or undetected side effects of medications.

Other mental and emotional disturbances have a physical cause. These disorders may be either a temporary brain dysfunction resulting from infections, fractures, malnutrition, heart failure or stroke, or a permanent mental impairment due to brain tissue deterioration. Chronic brain impairment can range from mild and easily managed, to moderate, or may even become severe enough to require intensive treatment.

The characteristics of such disturbances include:

- Disorientation to time, place and person. For example, older people with brain impairment may not know what day or month it is or may not recognize familiar surroundings or people.
- Memory loss. Older people's recent memory is usually affected more than their remote memory. For example, they may not remember what they had for lunch that very day but they may remember, in great detail, some incident which occurred many years ago.
- Inability to do simple calculations.
- Exaggerated emotional reactions. Older people may abruptly burst into tears or become extremely irritable over a small incident and may start smiling just as suddenly a moment later.
- Distortion in judgment.

Although we have discussed physical and emotional illnesses as separate entities, in reality they are closely related. An infection or a fracture can result in an episode of mental dysfunction. When the physical disorder is treated, the patient's mental functioning returns. Emotional illness may also precipitate physical illness—for example, depression may result in poor appetite and can lead to loss of weight and strength and to gastrointestinal disturbances.

Oregon State University
Extension Service

SP 54-038
February 1981

PUBLICATIONS ON SEXUALITY AND AGING

Human Sexuality and the Aging, by Mary Jo Pompeo. Discusses the biological, psychological, and social factors influencing sexual expression in the later years; sexual alternatives for individuals without partners; and sexual expression in long-term care facilities. (Center for Studies in Aging, P.O. Box 13438, NT Station, Denton, TX 76203; 1979; 52 pages; Price - $2.00.)

The Sensuous Heart: Guidelines for Sex After a Heart Attack. Dispells myths about heart disease and sexual expression and discusses adjustments following a heart attack. Written in large print and includes sensitively drawn cartoons. (Pritchett and Hull Associates, 2122 Faulkner Road, NE, Atlanta, GA 30324; 1978; 16 pages; Price - $5.00.)

Sex After Sixty, by Robert Butler and Myrna Lewis. A guide for older men and women. Information is provided about normal physical/sexual changes with age, common medical and emotional concerns, the single older person and sexual expression, dating, and remarriage, and seeking professional help. (Harper and Row, 10 East 53rd Street, New York, NY 10022; 1976; 165 pages; Price - $9.95.)

Sex Education, Counseling, and Therapy for the Aging. Discusses sexuality and the aging process, health and relationship-related problems in the later years, sexual dysfunctions, the knowledge base important for the educator, counselor or therapist who works with the older adult population, and sensate focus as a therapeutic technique. (American Association of Sex Educators, Counselors, and Therapists, Washington, D.C.; 1979; 23 pages; Price - $2.50.)

Sexual Consequences of Disability, edited by Alex Comfort. Addresses the effects of disability and surgery--including arthritis, diabetes, heart disease, stroke, prostatectomy, and mastectomy--on sexual function and well being. It is written primarily for the person who has a background in medicine or physiology. (George F. Stickley Co., 210 West Washington Square, Philadelphia, PA 19106; 1978; 296 pages; Price - $24.50.)

Sexual Education for Aged People, People Who Work with the Aged, and Families of Aged People: Program Development and Evaluation, by Charles B. White, et al. Presents the results of a study evaluating the impact of a sex education program on older adults, family members, and nursing home staff. Detailed information about the lecture-discussion sessions and teaching techniques makes the publication a useful guide for anyone interested in teaching classes about sexuality and aging. (Gerontology Studies Program, Trinity University, 715 Stadium Drive, San Antonio, TX 78284; 88 pages; Price - $8.00.)

Sexuality and Aging by Kathy Carroll. Consists of training materials--readings, quizzes, and case studies--for teaching about sexuality and aging. Sexuality is broadly defined to include touch, self-concept, and intimacy. Although the materials were designed for

OREGON STATE UNIVERSITY EXTENSION SERVICE

with long-term care staff, they can be easily adapted for other groups. (Ebenezer Center for Aging and Human Development, Minneapolis, MN 55407; Price - $4.00.)

Sexuality and Aging, edited by Robert Solnick. A compilation of fourteen articles presenting a variety of viewpoints on sexuality and aging. The major groupings of articles are: perspectives; physiological, psychological, and sociological issues, sexual growth; implications for nursing care; and the role of love in late-life sex. (Ethel Percy Andrus Gerontology Center, University of Southern California, Los Angeles, CA 90007, 195 pages; Price - $5.50.)

Use It or You'll Lose It, by Joseph Poticha and Art Southwood. Addresses the sexual needs, concerns, and problems of older adults. It is a personal approach, emphasizing self-understanding and communication between partners. Although written primarily for older adults, this book has value for younger persons also. (Richard Marek Publishers, 200 Madison Avenue, New York, NY 10016; 1978; 200 pages; Price - $8.95.)

Textbook of Sexual Medicine, by Kolodny, Masters, and Johnson. Oriented primarily toward the needs of health care professionals working with patients who have sexual problems; however, anyone interested in detailed discussion of topics such as heart disease, drugs, arthritis, and cancer and their relationship to sexual functioning, will find this publication helpful and readable. One chapter is devoted to sexuality of older adults. (Little, Brown, and Company, Boston, MA; 1979; 642 pages; Price - $18.95.)

The Starr-Weiner Report on Sex and Sexuality in the Mature Years by Bernard D. Starr and Marcella Weiner. Presents the results of a survey across the United States with 800 men and women 60 years of age and older. (Stein and Day Publishers, Scarborough House, Briarcliff Manor, NY 10510; Price - $14.95)

Loving Someone Gay by Don Clark. Explores what is means to be gay and gives the reader a greater understanding of the needs and adjustments of gay men and lesbians. One chapter is directed toward families, friends, and others who want to relate better to someone they love who is gay; another gives suggestions to help professionals improve their work with gay people. (New York, New American Library, Signet Paperback; Price - $2.25)

Prepared by Vicki L. Schmall, Extension Gerontology Specialist, Milam Hall 151, Oregon State University, Corvallis, OR 97331.

In the Middle Years: Sexual Fulfillment

Our sexuality is a privilege we are all born with, but we have to help it develop so that it enriches our lives.

—Dr. Abby Stitt
from *The Sexually Healthy Woman*

EC 1020
Oregon State University Extension Service
September 1980

Traditionally, sex was viewed as a function of the young adult for conceiving children. Our cultural attitudes implied sex ended for middle-aged and older people. Recent research, however, has found that sexual expression is important to the self-esteem and physical and emotional well-being of people at all ages.

The meaning of sex in mid and later life is often quite different from that in youth when physical stimulation and excitement may have been primary. With age, the emotional component—intimacy, the sharing of feelings, and being close to another person—generally assumes greater importance.

Advancing age sets no limits to sexuality. There are changes in sexual response and in the sex organs, but these changes imply a change in activity pattern, not an end to sexual expression. This publication explores facts and fallacies about midlife sexuality, the common sexual changes and their psychological and social impact, and how a person's attitudes, health, and life circumstances affect sexual response.

Midlife Sexuality Feelings

Last night Jack, age 42, was not able to obtain an erection. Panic has set in. He fears his sex life has ended. He asks himself, "Does this mean I am no longer a man? Will my wife reject me or feel rejected? If I try again, will I fail?"

Marcia, age 53, has found a renewed interest in sex and her sex partner. Menopause was a relief—no more worries about becoming pregnant.

Nancy, age 41, fears menopause and that it will be as difficult for her as it was for her mother. Will she go crazy? Is it going to mean the end of her womanhood? Will her husband still love her? These questions haunt Nancy.

Why the differences in response to midlife sexuality by Jack, Marcia, and Nancy? What does the inability to obtain an erection mean to a man—and to his partner? What factors may account for inability to obtain an erection? What does menopause mean for a woman? These are only a few of the many questions middle-aged persons raise about sexuality.

As with younger people, middle-aged adults sometimes are ignorant or misinformed about age-related sexual changes. Dr. David Reuben, author of *Everything You Wanted to Know About Sex But Were Afraid to Ask*, maintains that many men and women in midlife know more about their automobiles or golf clubs than they do about sex and sexuality. He states: "When you buy an automobile, they give you a wonderful book that tells you how to turn the key and what to do if something goes wrong. Most people find out about sex through on-the-job training. They start at fourteen or fifteen and make mistakes for thirty years. By the time they get the hang of it, it's too late."

Contrary to Dr. Reuben's last statement, it is never too late for partners to educate themselves about sexuality and to improve their sexual relationship.

Your attitude is particularly important. How do you feel about growing older? How do you feel about your partner's aging? What are your feelings about sexuality? Do you believe sexual expression ends at a certain stage or age in life (say when a woman reaches menopause or age 65, 82, or 95)? Do you see sexuality as an opportunity for personal fulfillment or as an obligation? What is your definition of "sexuality"? Do you define sexuality in broad or narrow terms?

What Research Tells Us

As in all age groups, middle-aged and older persons have different levels of sexual interest and activity. There is no specific age at which all sexual activity ends. People can and do continue to be sexually active into their ninth decade and beyond. People who enjoyed sex in early adulthood tend to continue to be sexually active. However, health and the availability of a physically healthy and willing partner become increasingly important factors affecting sexual expression. For people for whom sex has never been important or enjoyed, the aging process may provide a convenient excuse for giving up sexual activity.

Sexual response slows with age, but this change is no different than other physical changes adults experience. However, some people not recognizing this slowing as a normal part of the aging process assume it means an end to sexuality.

Research shows that many women reach their peak of sexual activity in their late thirties and early forties. Men, on the other hand, reach their peak in the late teens and experience a gradual decline in activity and interest. As a result, some couples find that their response patterns change during midlife, with the women becoming more responsive and the man less responsive.

Health is an increasingly important factor affecting sex drive after age 40, and especially after age 60. Serious illness may have an effect on

sexuality, and though few health conditions rule out sex altogether, some adjustments may need to be made. Certain diseases that become more common with age, such as diabetes and arteriosclerosis, can interfere with male potency.

A common fear among middle-aged adults with cardiac problems is the impact of sexual intercourse on health. Following a coronary, many people hesitate to resume sexual activity, fearing that it will precipitate another attack. Such incidents are rare. The sex act can be helpful to the patient if it reduces psychological tension.

Medications for health-related problems also may affect sex desire and potency. If you notice a change in sexual response when taking a new medication, ask your physician or pharmacist about it. Don't accept the change as inevitable.

Regular sexual expression is important in maintaining sexual responsivity. Research shows there is some truth to the phrase: "Use it or lose it." This is particularly true for the aging male, who is the most vulnerable to a lack of stimulation. In fact, as a male ages, a long period of abstinence (no sexual intercourse or masturbation) may result in an inability to obtain an erection.

Barriers to sexual activity in midlife are generally psychological and not physical. Embarrassment about sex, tension, work and family pressures, and mental fatigue are only a few of the causes for decreased sexual interest and responsivity.

Physiosexual Changes

As with other organ systems of the body, the sexual organs of both male and female undergo changes. These changes have little or no effect on ability to perform or enjoy sex. A danger, however, is that unless you and your partner understand these changes, you may misinterpret them. It is important for you to understand not only the changes you are likely to experience, but also the changes likely to be experienced by your partner.

The Middle-Aged Female

Physiologically, there is little evidence that age affects sexual capacity of women. Sexual activity can extend into the very late years. Reduced sexual activity in the middle-aged and older woman is generally the result of one or more of the following: husband's withdrawal from sexual activity, lack of an available partner, or "aging" becomes a reason for ending an activity she never found satisfying. The lack of a sexually capable and socially acceptable partner becomes increasingly significant as women age.

The menopause, which usually occurs in the late forties or early fifties, is probably the most significant physiosexual change experienced by the middle-aged woman. A number of myths and old wives' tales surround the menopause: "Menopause means the beginning of old age." "Menopause decreases a woman's sex drive." Contrary to popular belief, few women experience difficulties. Although the menopause means the end of a woman's reproductive years, it does not signal the end of her sexual enjoyment.

A woman's reaction to the menopause depends on her feelings about herself, her womanhood, and other sources of self-esteem. Many women find their sexual lives more rewarding and free of anxiety when family demands are reduced and the possibility of pregnancy is over. Some express renewed interest in sex and their sexual partners.

To some women, however, menopause means they are middle-aged and approaching old age. This is particularly traumatic for the woman whose youthfulness and physical attractiveness have been her primary sources of self-esteem. Also, women who feel childbearing is very important or who equate femininity with menstruation, may experience difficulty coping with the menopause.

A woman's sex drive following menopause relates to her attitudes toward sex and her earlier sex habits. Women who have not found sex psychologically satisfying or who regard it as an obligation, often find menopause a welcome excuse to end sexual involvement.

The most dramatic menopausal change is the decline in female hormone production. Symptoms commonly associated with this hormonal change are headaches, dizziness, excessive fatigue, breast and joint pains, mood swings, loss of appetite, palpitations of the heart (the heart seems stronger than usual), and hot flashes. Hot flashes, experiences of waves of heat over the face and upper half of the body sometimes followed by chills, last from a few seconds to a few minutes and can occur several times throughout the day. Some women report feeling totally drenched in perspiration following a hot flash.

Many of these symptoms are infrequent and do not involve enough women to be called "characteristic" of menopause. For example, only about 10 percent of women suffer marked discomfort; approximately 50 percent experience hot flashes to some degree. Symptoms vary from woman to woman.

A woman going through the menopause should remember to:

- Continue using contraception until she has had no menstrual periods for at least 2 years.
- Check with her doctor if periods are consistently heavy and long-lasting.
- Consult her doctor if bleeding begins after she has not menstruated for a year or more.

The decrease in estrogen production also affects the female genitalia. The vaginal wall gradually becomes thinner and loses its elasticity, resulting in rigidity of the vaginal tissue, especially at the entrance of the vagina. These changes are particularly significant for the older woman who resumes sexual intercourse after a long period of abstinence. Pain may be experienced with penile penetration. Lubricating jelly may help.

Lubrication of the vagina takes longer and diminishes in amount during sexual excitation as a woman ages. Therefore, more time may be needed for lubrication and response to stimulation. Again, lubricating jelly may help. Women who have a fairly regular sex life are less troubled by these changes.

It is important for women to remember that their partners may need education about menopause. Many men, as well as women, accept menopausal myths as facts. Knowledge generally helps men to better understand behavioral changes a woman may experience in this stage of the life cycle and to better provide the support and reassurances a woman may need.

The Middle-Aged Male

Men have less pronounced physical changes during midlife than women. As the male ages, the male hormone, testosterone, gradually reduces production between ages 50 and 90. The testes gradually become smaller and less firm and the testicular tubules begin to thicken and degenerate. This results in a lower rate of sperm production, yet males at very advanced ages can still father children.

In considering the sex act itself, males are less readily aroused than when they were younger; it takes middle-aged and older males longer to obtain an erection. The intensity of sensation, force of ejaculation, and amount of seminal fluid decreases. The time after orgasm before the male is ready for another ejaculation increases. The "resting time" needed varies. It may take a few minutes, several hours, or even a few days. In contrast, most young men need a rest period of only a few minutes between climaxes. One advantage some older males have is greater ejaculatory control—they can generally maintain an erection for a longer time period before orgasm. As a result, both partners may experience more pleasure.

The prostate gland is the organ most affected by the aging process and causes men the most problems. In their late forties and fifties, many men experience enlargement of this gland. Estimates are that more than 50 percent of males in their fifties suffer from an enlarged prostate, and this percentage increases with age. At age 80, for example, approximately 90 percent of males experience enlargement.

The prostate gland surrounds the neck of the urinary bladder where it connects to the urethra, the tube carrying urine and semen through the penis. The prostate is normally the size and shape of a chestnut, but enlargement can result in a prostate the size of a tangerine or baseball. As it enlarges, the prostate tends to pinch the

urethra and restrict the flow of urine from the bladder. Symptoms of an enlarged prostate include frequent urgency to urinate, inability to sleep through the night without urinating, difficulty in starting the urinary flow, an intermittent or weak urinary stream, and incomplete emptying of the bladder. Without treatment, urinary and kidney infections may occur.

Prostatectomy, the surgical removal of all or part of the prostate, becomes increasingly common among males past 50. Many men fear such surgery will cause impotency, the inability to obtain or maintain an erection (contrary to popular belief, prostate surgery does not mean the end to a male's sex life). Although radical prostate surgery can cause impotence, this type of surgery is the least common. The vast majority of males who are potent prior to surgery remain potent afterward.

A normal function of the prostate is to provide secretions that combine with the semen to form the ejaculate. Following surgery, there may be no external ejaculation, but rather, a retrograde discharge into the bladder. This does not eliminate the climax sensation but there may be no ejaculate. This need not affect a male's enjoyment of sexual expression.

A concern of many men is the slowing down of their bodies. Although men usually recognize the physical slowing as normal and adjust accordingly, some do not think of sexual functioning as just one more component of total physiological function. The slowing in sexual response is sometimes misinterpreted as sexual waning.

Impotency is a fear expressed by many men during middle age. Panic may set in when a man experiences for the first time an inability to get an erection. Some men withdraw from sex because they fear another failure, while others attempt a sexual encounter with another person to prove they do not have the problem.

In their book, *Human Sexual Response*, Masters and Johnson report that a man's inability to obtain an erection or engage in sexual intercourse relates to a range of nonphysiological factors such as overindulgence in food or drink, boredom, overwork, or anxiety about his ability to have sex. Performance anxiety (fear of failure) is the most common cause of male sexual dysfunction.

Physical bases for impotency should be investigated. Medications, high blood pressure, obesity, diabetes, and other physical problems can affect potency.

It is important that men and their partners understand the causes and impact of potency problems, particularly performance anxiety. Too often when an episode of impotency occurs, a couple is unable to talk about it. Men sometimes find such discussion difficult, particularly if they see impotency as a sign of weakness or if they feel totally inadequate as men. Partners sometimes feel personally rejected.

Where performance anxiety exists, it is important to provide relief from the pressure to perform and to keep open the channels of communication. A couple can find ways for sexual gratification that are acceptable and feel good to both of them, such as massaging, holding, and caressing. Questions that may help to identify factors that may be affecting male potency include:

- What demands are currently being made at home and work? Are the demands burdensome to him?
- Is he overworked or fatigued?
- Is he depressed over finances or other problems?
- Does he have a physical problem?
- Is he taking medication that may affect sexual energy and potency?
- Is he drinking more frequently than usual?
- Are his partner's sexual needs more than he can meet?
- Has his sexual relationship become monotonous?

Asking similar questions when a woman experiences a change in sexual interest and response also can provide additional insight.

Your Sexual Relationship

Sexual success is important for both men and women. "Success," however, is defined too often solely in terms of orgasm or sexual intercourse. There is more to sexuality—it involves giving and receiving tenderness, warmth, and affection, and feeling valued, attractive, and desired. It is feeling feminine or masculine.

Have you and your partner built these aspects of sexuality into your relationship? Or has emphasis been on the physical aspects of sexuality? Middle age is a time when both males and females need demonstrations of affection and reassurance that they are still attractive and competent. Such reassurance becomes particularly important when work, family demands, health, or age-related changes challenge one's identity and self-respect.

Do you or your partner judge sexual desires and behavior by youthful standards? If so, you are likely to experience disappointment and frustration. For a full and satisfying sexual relationship, focus on the person and the quality of relationship, not mere performance.

Do you and your partner openly communicate with each other? Good relationships are characterized by open communication in which you share your innermost feelings, sexual needs, and desires. Communication is two-sided. It includes the art of listening—really hearing and understanding what is being said. It is not too late to learn to communicate effectively.

It is not always easy for spouses to "tune in" to the needs of each other, particularly when both encounter simultaneous changes. For example, a woman experiencing menopausal adjustments may need the emotional support of her husband at a time when he is least able to provide support because of heavy work demands.

Is your relationship vital or has it grown stale? Some midlife couples find their relationship lacks zest. They have directed their energies toward child rearing and work demands and have neglected developing their relationship. Patterns sometimes become set. Even sex may have become a routine equivalent to washing dishes or cleaning house. According to James Peterson, author of *Marriage and Love in the Middle Years,* "Habit is the master of the unimaginative. And a habit, being so automatic, commands little attention. Habit in sexual activities cannot produce anything but lack of passion and response."

If this is true for you, find ways to make sexuality and your total relationship more stimulating. Add variety to your lives. Explore new vistas of sexuality and exciting things to do to enhance your relationship.

Are you staying physically fit and attractive? Your physical condition affects your interest in sexuality and your attractiveness as a sexual partner. Middle age need not be a time when your body "falls apart." But it is a period requiring better body maintenance than was necessary in younger years. As you grow older, exercise, rest, and a good diet become increasingly important for maintaining a vital body and mind.

Prepared by Vicki Schmall, Extension gerontology specialist, Oregon State University.

Extension Service, Oregon State University, Corvallis, Henry A. Wadsworth, director. This publication was produced and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914. Extension work is a cooperative program of Oregon State University, the U. S. Department of Agriculture, and Oregon counties. Extension invites participation in its programs and offers them equally to all people, without discrimination.

IS THERE A RIGHT WAY TO DIE?

BY NORMAN KLEIN

In Albert Camus's novel *The Stranger*, the protagonist, Meursault, commits an absurd murder and undergoes an even more absurd trial: he sees himself being judged not for his crime alone, but also for his failure to "emote properly" on the day of his mother's funeral. This "flaw" in his character influences the outcome of the trial and seals his doom.

In our own society, faddish therapies stress the idea that openly expressing sorrow, anger, or pain is a good thing, and the only means for "dealing with one's feelings honestly." "Holding things in" comes to be seen as deviant.

Yet nowhere has it been convincingly proved that expressing grief has universal therapeutic value. Perhaps more important, this insistence on the requirement to feel and tell represents an ethnocentric standard that can do injustice to persons and groups who cope differently.

Americans are said to fear and deny death, and if the denial becomes complete, it requires "defenses which can only be destructive," in the words of Elisabeth Kübler-Ross. She is perhaps best known for her scheme of the five stages of a "complete" death: (1) denial, (2) anger, (3) bargaining, (4) depression, and (5) acceptance. Each stage has a transitional value—taken alone, for instance, denial is seen as bad, though as a temporary buffer it is good—and, given enough time, a patient can reach a point of accepting death.

Kübler-Ross's work is undoubtedly useful; it may even help family, friends, and professionals to assist the dying patient who has the emotional needs she describes.

Yet it is surely conceivable that some Americans can work through grief internally or privately, without psychological cost; it is even more conceivable that whole cultural subgroups may have different ways of conceiving and responding to such experience. Harvard psychiatrist Ned H. Cassem has questioned the generally negative view of denial espoused by Kübler-Ross. "Denial can be a constructive force, enabling people to put out of mind morbid, frightening, and depressing aspects of life."

A cross-cultural perspective reveals how arbitrary any one such standard may be. In 1976, psychologists Paul Rosenblatt, Patricia Walsh, and Douglas Jackson used the Human Relations Area Files, a massive compendium of anthropological data, to examine

mourning in a large number of societies. They found in their review of 73 societies that what varies is the form and intensity of its expression. In 72 societies, people weep at death; the Balinese say they laugh to avoid crying. Are the Balinese unhealthy?

The researchers also correlated gender differences in crying for 60 societies: in 32 of them, both sexes cried equally; in the 28 in which there was a difference, it was always the women who cried more. Are they healthier?

In 18 of 32 societies, self-injury (such as cutting off a finger at a joint) is regularly attempted by both grieving men and women; women self-mutilate more in 12. But if emotional letting go is a good thing, should men and women, equally, mutilate themselves even more frequently?

Closer to home, psychologist Richard Kalish and anthropologist David Reynolds compared the attitudes on death and mourning of black Americans, Japanese-Americans, Mexican-Americans, and white Americans in Los Angeles. Asked if they would "try very hard to control the way you showed your emotions in public," the groups offered a wide range of responses. Japanese and black respondents said they would (82 percent, 79 percent) more often than white Americans and Mexican-Americans, for example (74 percent, 64 percent).

Japanese-Americans, who are most frequently reticent about public grief, would seem to bear out the stereotypic notion of Orientals as stoic. Public-health nurse Thelma Dobbins Payne reports that the reluctance of many Japanese-American women to cry out during childbirth leads some non-Japanese physicians to "wonder if Japanese women feel the pain." Japanese-American physicians, however, described a common alternative style in labor: "wincing," "grimacing," "frowning."

How much and what type of emoting is necessary to avoid the label "stoic"? The real issue rests with the way the various cultures define the appropriate expression of emotion. At the same time, it is very important to note that in no group Kalish and Reynolds studied was there a 100 percent agreement by all informants—sex, age, religion, and education all affected the responses.

"Death with dignity" and "a beautiful death" verge on becoming the new jargon of concern. But for whom are these expressions really meaningful? Do they describe the dying person's experience, or the observer's? Attitudes toward death are clearly influenced by culture—and by subculture and by individual personality. It follows, then, that we must take care not to formalize or prescribe the way in which people express emotion. As Kalish and Reynolds remark in their discussion, "This era is in danger of replacing old myths and stereotypes with new myths and stereotypes, slightly more accurate and less destructive perhaps, but nonetheless not always appropriate." Ω

Norman Klein is associate professor of anthropology at California State University in Los Angeles, and editor of the forthcoming "Culture, Curers, and Contagion."

Reprinted with permission from Psychology Today Magazine. Copyright 1978 (APA).

When Friends or Patients Ask About . . .

William H. Crosby, MD, *Section Coordinator*

Courtesy of Geigy Pharmaceuticals

Preparing a Child for a Good-bye Visit to a Dying Loved One

Judith S. Rubenstein, EdD

DEATH is never easy to explain to children, particularly younger ones. Experts may compound the problem by giving parents vague generalizations, such as "explain death honestly to the child," without suggesting specific phrases to use. The parents still remain at a loss for words and may feel even worse than they did before they received the advice, because now they think they should know what to say.

Preparing a child for a "good-bye" visit to a dying loved one is an aspect of death that probably has received the least attention. It is not customary, in the United States, to take a child on such a visit. The epitome of this exclusion may be found in "Gone With the Wind": when Melanie is dying, all of the most meaningful people in her life get to say good-bye to her, except her child.

For editorial comment see p 2569.

When my father-in-law was dying of cancer, my husband and I decided to take our two older children, 6 and 4 years old, on a good-bye visit to him. To prepare the children for this visit, we talked with them a few days beforehand, trying to anticipate what they would see and what they might feel. The words and phrases we used worked well for us. Perhaps they may help others facing a similar situation. I report the situation and our words below.

The Situation

There was no denying Grandpa was dying. My husband, who rarely travels, was suddenly making frequent, short trips to Chicago to visit him. The children overheard the anxious, daily, long-distance telephone calls to or from my mother-in-law, and afterward the anxious conversations between my husband and me.

The children had had a loving relationship with their Grandpa, built on pleasant visits several times a year when Grandma and Grandpa would come to Boston from Chicago. I remember in particular tireless sessions teaching toddlers to walk, and then later, long intimate walks, sometimes including "rest stops" at the candy or toy store.

Because of this warm relationship, we felt that the older children were entitled to say good-bye to him. (We felt that our 2-year-old was too young to understand.) We decided that I would take our 6-year-old daughter to Chicago on one trip, and my husband would take our 4-year-old son on a separate trip.

Many people, friends and family, strongly objected. They said, "We have never heard of such a thing." "Let them remember him the way he was." "He has deteriorated, and his changed appearance will frighten them." We rejected this well-meaning counsel in the belief that children have to learn that, however sad, sickness ending in death is part of life and that human beings have a need to say good-bye when time shared is over, whether it is a short, social visit or life itself.

Our Words

My husband and I together spoke to each child alone. We chose the time after breakfast one morning, since our children were most refreshed and alert at that time of day. Also, they had the rest of the day to think and ask questions. (Speaking of such an emotional concept in the evening would only have upset bedtime.) Our presentation to each child took only five or ten minutes, including questions from the child and repetitions by us. We began something like this: "We have something important to talk to you about. Come and sit on my lap. I'm going to Chicago in a few days to see Grandpa, and I'd like to take you with me, if you want to go. Before you decide, listen to what we have to say."

The children wanted to go. They responded to our statements as we made them, and my husband and I backtracked and repeated, and our presentation was not a smooth monologue, but we did speak the following phrases in more or less the following order:

1. "You know Grandpa is very sick."
2. "He is going to die soon."
3. "This probably will be the last

If you wish to suggest a topic or write an answer for this feature, write to William H. Crosby, MD, Walter Reed Army Institute of Research, Washington, DC 20012.

Dr Rubenstein, an educational consultant, lives in Winchester, Mass, with her husband and four children.

Reprint requests to 23 Yale St, Winchester, MA 01890 (Dr Rubenstein).

Reprinted from the Journal of the American Medical Association
May 14, 1982, Volume 247
Copyright 1982, American Medical Association

time you will see him."

4. "He's changed a lot since you saw him last."

5. "He looks terrible."

6. "He's very thin."

7. "He's very pale."

8. "He's very weak."

9. "He probably won't talk much."

10. "He may cry."

11. "But you don't have to be afraid."

12. "He's still your same Grandpa."

13. "He's unhappy because he knows he's going to be dying soon, and he doesn't want to leave us."

14. "You may give him a big hug and kiss."

15. "It will make him feel better."

16. "You don't have to be afraid to kiss him."

17. "You can't catch his sickness. It's not a kind of sickness you can catch."

18. "You love your Grandpa, and he loves you."

19. "You may tell him you love him, if you want to."

20. "That will make him feel good, too."

Following our explanation, each child asked more questions. Both children wanted to be reassured that they wouldn't catch any "germs" from Grandpa, and we repeated that his illness didn't have germs one could catch. Then the conversation turned to details of travel in the airplane, who else we would see in Chicago, and more questions about "germs." Then, before the questions and repetitions became too great, and the emotional tension turned to annoyance, we ended the conversation with: "We have talked enough for now. If you have any questions or if you want to talk about it again, you can ask us later. You can go play now."

Throughout that day and the following ones, the children asked questions from time to time, while I was preparing a meal or folding laundry, or doing some quiet task not focused on the child, and we discussed the ideas again, but in a more casual way.

The Visit

A few days later, when my 6-year-old daughter and I visited my father-in-law, he was in pajamas in a wheelchair in the hospital waiting room. A compassionate physician and a humane hospital policy made this possible. My daughter approached him with poise, self-confidence, and affection, without fear, lugubriousness, or false cheerfulness. She said, "Hi, Grandpa." She reached up and put her arms around his neck and kissed his cheek. She smiled coyly, and handed him a slip of paper on which she had drawn a picture and written, "I love you."

Grandpa and granddaughter hugged each other and smiled. The old man started to cry, and the little girl slipped down and sat on a chair. The adults talked a while longer, and then we left. As I pushed open the heavy glass doors to leave, my daughter turned and waved good-bye to Grandpa and followed me, skipping and smiling. The next week, my husband told me that he and our 4-year-old son had a similar experience at their visit.

In the years following my father-in-law's death, our children have mentioned that last visit from time to time. Although their remembrance of specific details, including their conversation, has blurred, they speak of the visit with a certain wistful pleasure, which makes us happy that we did not deny it to them.

Special thanks for editing of the manuscript go to Daniel R. Rectanus, MD, and Howard S. Rubenstein, MD, University Health Services, Harvard University, Cambridge, Mass.

#399-2468-D

Printed and Published in the United States of America

When someone we know is facing an illness, especially a serious illness, we often feel helpless. We stammer the weak phrase: "Just call if you need something" -- Have you gotten a call lately? Here are some practical tips to really help someone facing an illness...from people who have been there.

1. Don't avoid me. Be the friend...the loved one, you've always been.

2. Touch me. A simple squeeze of my hand can tell me you still care.

3. Call me to tell me you're bringing my favorite dish and what time you are coming. Bring food in disposable containers, so I won't worry about returns.

4. Take care of my children for me. I need a little time to be alone with my loved one. My children may also need a little vacation from my illness.

5. Weep with me when I weep. Laugh with me when I laugh. Don't be afraid to share this with me.

6. Take me out for a pleasure trip, but know my limitations.

7. Call for my shopping list and make a "special" delivery to my home.

8. Call me before you visit, but don't be afraid to visit. I need you. I am lonely.

9. Help me celebrate holidays (and life!) by decorating my hospital room or home or bringing me tiny gifts of flowers or other natural treasures.

10. Help my family. I am sick, but they may be suffering. Offer to come stay with me to give my loved ones a break. Invite them out. Take them places.

11. Be creative! Bring me a book of thoughts, taped music, a poster for my wall, cookies to share with my family and friends...an old friend who hasn't come to visit me.

12. Let's talk about it. Maybe I need to talk about my illness. Find out by asking me: "Do you feel like talking about it?"

13. Don't always feel we have to talk. We can sit silently together.

14. Can you take me or my children somewhere? I may need transportation to a treatment... to the store...to a doctor.

15. Help me feel good about my looks. Tell me I look good, considering my illness.

16. Please include me in decision making. I've been robbed of so many things. Please don't deny me a chance to make decisions in my family...in my life.

17. Talk to me of the future. Tomorrow, next week, next year. Hope is so important to me.

18. Bring me a positive attitude. It's catching!

19. What's in the news? Magazines, photos, newspapers, verbal reports, keep me from feeling the world is passing me by.

20. Could you help me with some cleaning? During my illness, my family and I still face: dirty clothes, dirty dishes, dirty house.

21. Water my flowers.

22. Just send a card to say "I care."

23. Pray for me and share your faith with me.

24. Tell me what you'd like to do for me and, when I agree, please do it!

25. Tell me about support groups like Make Today Count so I can share with others.

Saint Anthony's Hospital Make Today Count dedicates this list to all the Make Today Count Members we have loved and shared with and to those who need to know...they are nor forgotten.

reproduced with permission from:

SAINT ANTHONY'S HOSPITAL
Make Today Count
St. Anthony's Way
Alton, IL 62002
618-465-2571

Hospice

John W. Abbott*

Many Americans, when confronted with a diagnosis of a terminal illness, have been told that there is nothing more that professional health personnel can do. The result of this has been that many patients are forced to live out their remaining days experiencing pain and other symptoms without adequate medication to relieve their discomfort and suffering. Their psychological, social, and spiritual needs have also been ignored, and their families have had to cope alone during the traumatic period of the illness as well as in the bereavement period following. The result has been that many have died without anything resembling a sense of fulfillment.

When Hospice, Inc. of New Haven, Connecticut began to care for terminally ill patients in their own homes, and to work with their families as well, an important new approach to health care was inaugurated. The date was 1974. Though St. Christopher's Hospice had opened its inpatient doors in London in 196", the New Haven program was the first in this country. With the help of a three-year contract with the National Cancer Institute, Hospice, Inc. was able to run a national demonstration center for home care of the terminally ill and their families. Since that 1974 beginning, Hospice, Inc. has cared for nearly 600 patients and their families.

The movement has spread rapidly throughout the country since then. About 200 hospice programs are in various stages of planning and development in 39 states plus the District of Columbia, and the number is growing. The National Hospice Organization, which brought nearly 1,000 people to the Fifth National Hospice Symposium in Washington, D.C. in October, 1978, is providing signal leadership to the movement with special attention to the implementation of standards for local hospice programs of care. NHO accreditation will be necessary for use of the "Hospice" name.

Many important questions are being raised about Hospice, and this article will answer some of them.

The Goals of Hospice

The Goals of the Hospice program are succinct and compelling:

- To enable the patient to live as fully as possible.
- To support the entire family as the unit of care.
- To make it possible for the patient to remain at home as long as home care is appropriate.
- To supplement rather than to duplicate existing services.
- To keep costs down.

* *Mr. Abbott is Director of Public Information for Hospice, Inc. of New Haven, Connecticut.*

Reprinted with permission from Department of Health and Human Services, 200 Independence Ave., SW, Washington, D.C. 20201.
Reprinted from Aging Magazine.

Hospice Aids the Patient and His Family.

Patient care begins with a strong feeling that patients should be as comfortable as possible during the latter days of their illness. Such comfort comes about through regular control of pain and management of the numerous symptoms (such as nausea, shortness of breath, etc.) associated with terminal illness. If the patient's condition warrants, medication is administered on a regular basis before the patient actually feels the need. The source of what the patient interprets as pain must often be tracked down and help provided to meet each symptom. The aim is to find the point at which discomfort stops but before sedation is effected.

Hospice recognizes that a terminal illness affects every member of the family. Sometimes what is needed is a sense of assurance that help will be available in the event of an emergency in the middle of the night or on a holiday weekend. Hospice staff make regularly scheduled visits but are available 24 hours a day, 7 days a week to make house calls when their help is especially needed.

Another concern expressed by family members is whether they will have sufficient information and knowledge with which to provide the care which they desire to give. When people ask, "*Can* we care for our loved one?" Hospice answers "Yes, you can, and we will help you." Thus Hospice teaches family members how to care for patients, how to give medications, how to prepare tasty but nutritious foods and other practical things. Hospice also educates the family regarding the progression of the illness so that no one will be surprised by new developments.

A major characteristic of a Hospice facility should be its homelike and non-institutional atmosphere.

Beyond these matters, often what is needed is simply a feeling—demonstrated by positive action—that someone really cares about the family enough to take time to listen to family problems, needs, fears, and anguish. Hospice staff and volunteers must be good listeners. A visit from the Hospice home care team is not a brief in-out encounter but an experience which lasts as long as necessary to meet needs as they arise at any given moment.

Many family members have said, following the death of the patient, "You helped us to do what we wanted to do."

Family care continues throughout the bereavement period. Every family, following the death of the patient, receives a visit from the nurse who carried the primary responsibility, as well as periodic telephone calls. If the family needs additional help in coping during that difficult period a volunteer bereavement team assumes a continuing role for as long as its help is needed.

Providing Care

Care is provided by an inter-disciplinary team which is medically directed and nurse coordinated. Individual team members include physicians, nurses, a social worker, and chaplain; on-call consultants including a psychologist, dermatologist, and physical therapist; and trained home care volunteers. An individual plan of care is worked out for each patient and family, and the entire resources of the team are available to meet individual needs as they develop.

Eligibility criteria for patient care include:

- A diagnosis of cancer. (Hospice hopes to care for persons suffering from other conditions after its inpatient facility is opened.)
- A limited prognosis (six months or less).
- We prefer that there be a primary care person in the home. Usually this would be a relative, occasionally a friend, who is able to take continuing responsibility for patient care.
- Consent and cooperation of the patient's physician who usually remains the primary physician on the case.
- Residence in one of 12 cities and towns in the area of New Haven, Connecticut. Ultimately the home care program will be expanded to a 20 town area which comprises an HSA (Health System Agency) region, one of five in Connecticut.

Hospice Volunteers

Hospice has several physicians and nurses who provide volunteer service in addition to paid staff members of those disciplines. Other volunteers read to patients, provide automobile transportation, stay with the patients while family members go out of the house, assist family members with chores, and do whatever most needs to be done. One volunteer took a patient, a life-long fisherman, fishing, because

that was what the patient most wished to do. All Hospice volunteers have a strong commitment to helping other people.

An initial screening and orientation program, conducted by the Hospice director of volunteer services, is the first step in a training process which included formal orientation sessions and "on the job" training experience in which prospective volunteers visit patients with experienced members of the team. Once accepted into the program, each volunteer functions in

A tangible indication of the success of the Hospice program of care has been the increasing percentage of patients enabled to die in their own homes.

the way best suited to that volunteer. At any point Hospice in New Haven is likely to have about 40 active home care volunteers and at least 50 on the waiting list.

Service Costs

Previous mention has been made of a contract with the National Cancer Institute which funded the operation of the home care program as a demonstration project during the first three years of its operation. When the contract expired Hospice began to make a regular charge for visits from the home care team staff. The stated charge is $29.00 per visit. Much of this cost is borne by third party payers. As a Certified Home Health agency under Medicare, Hospice receives Medicare reimbursement. It also receives payment through Medicaid, Blue Cross of Connecticut, and private insurance companies which are required by Connecticut law to include home health care in insurance coverage. Hospice also has grants from Title XX and Title III which help to pay for patient care costs. If a patient is not covered by third party payers a sliding scale is applied. No patient is turned away from this or any other Hospice program for lack of ability to pay. Ultimately, changes will be needed in laws and regulations governing reimbursement for Hospice services for patients and their families.

Inpatient Care

Though the major thrust of the Hospice movement in the nation is geared to medically directed home care, inpatient care is also important. The first Hospice inpatient building in the country, specifically designed for care of the terminally ill and their families, will be opened by Hospice, Inc. in Branford, Connecticut in October 1979. At present, inpatient facilities are encompassed within existing health care facilities. Whatever form the facility takes, it is important that it and the home care program are operated autonomously under the same administration so that there is continuity of care for patients as they move back and forth between home and facility.

A major characteristic of a Hospice facility should be its homelike and non-institutional atmosphere. Provisions must be made for the participation of family members in the care of patients. The Hospice facility in Branford will provide large windows looking out upon an area which includes a school, church, and residential areas, thus avoiding a sense of isolation and abandonment which often affects the terminally ill patient. There will be small kitchenettes so that family members may prepare special foods. A chapel will provide a center for spiritual emphasis. Beds may be moved outdoors when weather permits.

The $3.5 million cost of the Branford building has been paid for through a $1.5 million grant from the State of Connecticut, a $1 million grant from the U.S. Department of Health, Education and Welfare, and $1 million in contributions from foundations, corporations, individuals and organizations.

The Results of the Hospice Program

A tangible indication of the success of the Hospice program of care has been the increasing percentage of patients enabled to die in their own homes. The figure has climbed from somewhere in the vicinity of 50 percent when the program first opened to 76 percent during the past 10 months. Family members indicate their sense of satisfaction with the results of the family support system engendered by Hospice. Studies indicate positive personal results in the lives of patients and family members.

One Hospice patient summed it up saying "I want to live until I die, if you know what I mean." Hospice is hard at work helping people young and old to live as fully and completely as possible during whatever time they have left. Emphasizing life, its fullness and quality, rather than death, Hospice is bringing new hope to those who once thought that nothing more could be done, and found that such was not the case.

☆U.S. GOVERNMENT PRINTING OFFICE: 1979 O— 281-694/5

Concept 4.5
Strategy 1

Death —a family crisis

Most of us avoid thinking about death even though we know it is a crisis that eventually affects every family. When family members or close friends die, the word "dead" is sometimes glossed over by using departed, passed on, passed away, or gone to heaven. Death has become such a taboo subject that mourning is viewed as a weakness rather than as a necessity.

In American and other Western cultures we no longer carry out many burial customs or mourning etiquette which specifies a course for grieving persons to observe. "Widows weeds" are no longer worn; nor do most families wear a mourning band. The crepe placed on the door of a home to symbolize a death is rarely seen. As we deny the fact that death and bereavement are inevitable, we also provide few guidelines for overcoming this crucial event.

In the past death was a constant part of ily living. The high death rate at early ages, close location of relatives to one another, and burial on the family farm or rural cemetary made death an integral part of family life. As the customs surrounding death and bereavement are yielded, families often feel left alone in their grief. In societies where rituals for the dead are established the role of the mourner is easier. There is a recognized time during which the bereaved take leave of the dead and realize their loss. They then begin

PNW 88 Reprinted February 1983
A Pacific Northwest Extension Publication
Oregon • Washington • Idaho

2

the process of adjustment and eventual return to the mainstream of life. It may seem strange to impose time limits on such a personal experience as grief. However, it provides guidelines which can protect the bereaved from suppressing their grief or from remaining in perpetual mourning.

Although there is no universal pattern for appropriate behavior for the bereaved, grief is a normal emotional expression. Suppression of grief can have undesirable effects. Many Americans are influenced by a belief that they must be strong and find it difficult to weep or show the intensity and loneliness of their crisis. Others respond naturally to their sorrow by openly weeping.

As with all emotions there is no one *right way* for expression. Restraining grief may extend the period of adjustment and recovery, affecting all of one's personal relationships and the return to normalcy. Grief precedes a reformulation of purpose that does not leave out the relationship with the dead but gradually seeks new attachments and commitments.

Stress charts based on case histories reveal that the death of a spouse is the most intense crisis a person can experience. The physical effects of the loss, and the drain on emotional energy and resources are of greater duration than other crises. The severity of change often causes a period of disorganization and uncertainty that may take several years to resolve.

Every religion has beliefs that deal with death and grief in terms of faith and philosophy. Throughout the centuries people have tried to understand death and how to cope with grief. Elisabeth Kübler-Ross, a pioneer in the study of death and dying, says that we cannot really live until we face our own death and realize we are all like snowflakes; each beautiful, different, and very temporary.

Some understanding of the nature of the grief and bereavement process is an important preparation for life. This understanding will help

3

during bereavement and enable us to give sympathetic support to others who are bereaved.

Reactions to Bereavement

No two people react the same to any crisis. People grieve in their own special way and at different times. The circumstances of death, the age of the deceased, the relationship to the person, one's own physical health, and other circumstances will affect personal reactions. We work through most of these reactions as we move toward recovery.

- A feeling of numbness and shock. There may be a physical reaction. A vague feeling of detachment.
- A feeling of disbelief; this isn't happening to me. Dreams in which the deceased is present.
- A feeling of desertion and even resentment at being left alone.
- A feeling of loss and grief; sorrow for the loved one who can no longer enjoy and sorrow for ourselves for having to go on without the deceased.
- A feeling of guilt. Why wasn't I more patient, loving or understanding? Why didn't I do more for him/her?

  A feeling of self pity. Why did this happen to me? What have I done to deserve this? Why was I picked out for this fate?
- A feeling of depression. Loss of interest in life. No one cares about what has happened to me.
- Enshrinement. A concentration on the dead, depriving the family of needed companionship. Elevating the deceased to sainthood.
- A feeling of anxiety. What will I do now? How will I manage?
- For some, religious beliefs are tested in attempting to find explanations.

4

Most of the reactions to bereavement are worked through as we move toward recovery. When we realize that our behaviors or feelings are not unusual, it is easier to accept ourself and come to terms with our loss. Recovery is evident as we gradually enjoy ourselves without guilt and discover that our initial reactions to bereavement are quietly dissolving.

Recovery from Bereavement

Those who are bereaved can work at their recovery process if they:

- Accept the fact that wishful thinking will not bring back the loved one.
- Accept sorrow as normal rather than suppressing it. Express grief openly.
- Talk to others about their loss and personal feelings.
- Accept support and help from others.
- Remember that others who are grieving need emotional support.
- Seek professional help if their efforts seem inadequate.
- Plan to help themselves rather than hoping time will solve the situation.
- Give themselves opportunities for new relationships and new interests.
- Expect that recovery is two steps forward and one step backward. Recovery does not move ahead in an orderly fashion.
- Recognize that adjustment requires a reformulation of purpose which includes a different relationship with the deceased and a new commitment to the future.
- Explore the solace of religious faith.
- Know and manage the financial situation.
- Limit major decisions about family life or living arrangements until the stress has subsided.
- Do not expect too much of themselves or their children during stressful times.

5

Helping Children

It is difficult to help a child understand death. There are no simple formulas for accomplishing this task. Helping children is especially hard when parents are upset and have their own difficulties dealing with the death of a loved one. We know children generally react to the event in predictable ways at certain ages, however, which can provide some assurance for parents.

Although children differ, the young child from 3 to 5 usually denies death. They may express sorrow but seem calloused as they run away to play as usual. They think of death as a journey or sleep from which the deceased will return. Words used to explain death should be chosen carefully. A child who is told that grandfather is sleeping may become anxious and fearful at bedtime. Another explanation commonly used is, "God took Grandpa." This, too, can backfire. A child wonders if God might also do that to others and may develop fears that God, at any moment, may take someone else in the family.

As children grow older they appear to be able to accept the finality of death. Between ages 5 and 9 children can accept that a person has died, that they are no longer breathing, and that they will not return to life. By the time children are 9 or 10 they accept the finality of death, realizing that it is inevitable for everyone. This realization, however, seems to be mostly intellectual because most of us do not really confront our eventual death until in the middle years.

Parents differ in their reactions to death and many well-meaning behaviors and interpretations leave children with strange misconceptions. Concerned parents may hide their own grief from children or try to protect them from family mourning and funeral experiences. Children sense that something is wrong and need the reassurance that comes from sharing a family experience. The desire to spare children often in-

6

tensifies disturbed feelings and increases bewilderment about death.

Some ways to discuss death may allay children's fears about death for themselves, their parents, or friends. Explain that death is usually the result of an accident, illness, or old age. Since children tend to personalize ideas, it is important that they realize that what has happened to Grandpa is not likely to happen to them. "Grandpa was very old, and his body could no longer keep him going." Stress that this happens to everyone's body when it is old. In discussing sickness it can be explained that science has not discovered ways to cure all diseases. An accidental death can be used to emphasize the importance of protecting ourselves from dangerous situations.

How children react to death is often confusing to adults. Some children express sorrow and then seem to go on as though nothing has happened, while others may play-act death with elaborate funeral scenes. Both responses are often hard for adults to accept, but we should be grateful when feelings are being expressed rather than kept inside. Even a funeral for a pet or a dead bird is preparation for later bereavement experiences.

Sometimes children are exposed to other emotional trials when a family member dies. Parents in their own distraught state may give the impression that the deceased person had greater significance than those who survive. The death of a child in the family may bring out parental hostility toward remaining children or the children of others. Unconscious resentment and harsh expectations may be taken out on unsuspecting children who are still alive, active, and healthy.

Another kind of emotional trial for children is the use of a dead parent to make children behave. "Your father would never approve of what you are doing." This is unfair to the child who cannot rebel against a memory and unfair to the deceased who is being set up as a judgmental tyrant.

7

More often than we realize children feel that they were somehow responsible for the death. They made noise when the deceased was ill or failed to mow the lawn for Dad. Older children are more apt to talk about their feelings and guilts than younger ones, but children of every age need time to work out their thoughts and to have a ready listener when they are ready to talk.

There is no one way to include children in grieving or funeral ceremonies. Sparing them usually is unwise, as they feel shut out from something terribly important. Being left out leads to a sense of abandonment, which is uncomfortable at any time. Being separated from the family may lead to anxiety that will have further reaching effects than the entire upsetting sadness of the experience.

What is important when children experience death and mourning? Remember that they are children and may not now recognize the full meaning of death, nor it's permanence. They cannot react in the same way as an adult, but they too need inclusion, honesty, and loving care, as does any grieving adult.

Thinking Ahead

No one likes to dwell on death, but you should think about ways to cope with the situation.

Decision-making at the time of crisis can be very disorganized. Discussing facts and being aware of legal and financial affairs will make decisions easier when death comes.

- Who will you rely upon for advice and help?
- What funeral director will you call?
- What type of funeral do you prefer for yourself and family members?

8

- What is your thinking about funeral expenses? What is the difference between the least expensive and the most expensive funeral?
- Where will you want family members buried? If you prefer cremation, what disposition should be made of the remains?
- Do you have a will?
- What immediate financial assistance will be forthcoming?

Suggested Reading

Caine, Lynn. "Widow." New York: Bantam Books, 1975.

Grollman, Earl A. (ed.). "Explaining Death to Children." Boston: Beacon Press, 1967.

Kastenbaum, Robert. "Psychology of Death." New York: Macmillan Company, 1969.

Kubler-Ross, Elisabeth. "On Death And Dying." New York: Macmillan Company, 1969.

Lewis, C. S. "A Grief Observed." New York: Bantam Books, 1976.

Marshall, Catherine. "To Live Again." New York: McGraw-Hill, 1957.

Marcelle

Prepared by Oregon State University human development specialists

Published and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914, by the Oregon State University Extension Service, Henry A. Wadsworth, director; Washington State University Cooperative Extension, J. O. Young, director; University of Idaho Cooperative Extension Service, H. R. Guenthner, director; and the U.S. Department of Agriculture cooperating.

The three participating Extension Services offer educational programs, activities, and materials without regard to race, color, national origin, or sex as required by Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972. The Oregon State University Extension Service, Washington State University Cooperative Extension, and the University of Idaho Cooperative Extension Service are Equal Opportunity Employers. 25/25/25

Oregon State University
Extension Service

Leader-Teacher Guide

When Death Comes: Understanding Grief

Prior to Lesson

- Read carefully through the leader-teacher guide and books available at your library on grief
- Outline your presentation
- Obtain needed materials: Paper for study group members
  Newsprint or other paper on which to write major points of your presentation and the responses of study group members to questions
  Felt-tip pen

The Lesson

Introduction. Tell group members, "This lesson will focus on grief and our attitudes, feelings, values and responses to grief. Together we will explore our varied reactions to situations causing grief, how we can more effectively help the grief-stricken, and how we can help ourselves deal with loss."

Emphasize that dealing with grief is never easy, but the more knowledge we have about grief, the more understanding and effective we are likely to be in handling grief.

Encourage study group members to contribute their insights and experiences throughout the lesson.

ACTIVITY. Have the study group members tear a piece of paper into three pieces. Ask them to write on each piece of paper something they really value.

Ask them to hold in their hand the slip of paper that represents the person or thing they value the most. Tell them that circumstances are such that they have lost what they value the most. Tell them to crumple the paper and throw it on the floor (or you may have a waste basket in which they throw the paper). Or, you may go around and pull the paper from their hand.

Ask members to write their feelings on a piece of paper. How do they feel about the loss?

After a few moments tell the study group members that within three

Extension Service, Oregon State University, Corvallis, Henry A. Ellenwood, director. This publication was produced and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914. Extension work is a cooperative program of Oregon State University, the U. S. Department of Agriculture, and Oregon counties. Extension invites participation in its programs and offers them equally to all people, without discrimination.

months of their first loss, they lose the second thing which they most value. Again, have them crumple the paper and throw it away. Tell them to write down any additional feelings.

Repeat with the third piece of paper. Use reactions to the exercise for the discussion about grief.

Discuss Loss. Ask study group members, "What were the things you wrote on your pieces of paper that you valued most?" Many will mention people who are important in their lives--spouse, children, parents, friends. Find out if there were "things" (for example, a home) or "values" (for example, independence) that were listed.

Emphasize that we usually think of grief as associated with the death of a loved one, but other types of circumstances can bring about grief. GRIEF IS OUR REACTION TO ANY LOSS -- a valued object, a marital relationship that ends in divorce, a cherished friendship, job, security, status, health, as well as a loved one. We often experience grief over things we lose in which we have invested our affection, money, time and energy.

Stress that EACH PERSON'S GRIEF PROCESS IS UNIQUE. Make the following points:

- No one can tell us how long, or in what manner, we should grieve. Grief for each person is very personal and unique. However, when people do not understand this, misunderstandings can occur.

- Because one person mourns in a way different from another individual, this doesn't mean that that person's grief is any more "heavy" or "lighter".

- What is "normal" grief for one person may be "abnormal" for another.

- Mourning is finished when the tasks of mourning are accomplished. It is impossible to set a definite date for this. In the loss of a significant relationship, such as a spouse or a child, it will take a minimum of a year for most people. One study found that for women who lose their husbands, fewer than one-half reported they were back to their old selves after one year. For some widows it took three to four years to reach stability in their lives.

- One benchmark of a completed grief reaction is when the person is able to think of the deceased (or other loss) without pain and can reinvest his/her emotions back into life.

State that there is a sense in which mourning can be finished and there is a sense in which mourning is never finished. Freud, in writing to a friend who had lost his son, stated:

> "We find a place for what we lose. Although we know that after such a loss the acute stage of mourning will subside, we also know that we will remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it is filled completely, it nevertheless remains something else."

Emphasize what this statement has to say to us about grief. Many times people respond to certain losses as though they are "replaceable". For example,

a person loses their pet and someone will say, "At least you can always get another dog (cat, bird, etc)" or "You'll just have to get another pet right away." To a woman who has had a miscarriage, you sometimes hear people say, "You'll have to have another child" or "Be thankful you have your two children."

The ability to cope with a loss and to adapt is influenced by many factors, including the following three factors: (1) The nature of the loss, (2) the character of the person experiencing the loss, and (3) the support provided to the person.

The Nature of the Loss. A person's reaction to loss is affected by it's timeliness, duration, potential of the loss for triggering other losses and the significance of the loss. When a loss is seen as appropriate, for example, an adult child leaving home, the adjustment is usually easier than when a loss is unexpected. Death of an older person or someone following a long illness may be easier to adjust to than when a child dies or the death is sudden and traumatic.

A death, which means a permanent separation, is more difficult to adjust to than a temporary separation. However, the most difficult separations are those in which the termination is unknown such as soldiers missing in action, families separated during war who do not know if they will be reunited, and runaway and abducted children with whom parents never again have contact.

The potential a loss has for triggering other losses has an impact on adjustment. For example, a divorce may mean not only the loss of a spouse, but also a move, loss of friends, reduced income, and loss of children. A move to a nursing home for an older person may mean loss of home, personal possessions, independence and decision-making.

The greater the emotional investment a person has made in the "object" of loss, the more difficult will be the adjustment.

The Person Experiencing the Loss. The previous coping style of a person for dealing with crisis and change influences how a person copes with a current loss. A person who has experienced multiple losses within a short time may not have the emotional resources for dealing with another loss. The result may be bereavement overload.

Discuss Bereavement Overload.

ACTIVITY. Ask study group members how they felt as their losses mounted in the exercise. With each loss, what changes did they feel in their ability to cope? Discuss the feelings they wrote down following each loss.

Emphasize that it becomes more difficult to cope with a loss when losses are cumulative. When one loss or death closely follows another, often there is not enough time to work through the grief associated with one loss before facing another loss. An individual's resources for coping can be severely strained. And, the person is even more likely to experience confusion and disorganization.

Older people are particularly vulnerable to bereavement overload. Their losses are often multiple. And, their opportunities and

resources for replacing their losses and developing new relationships often are less than for younger people. Some of the negative behavior patterns associated with old age actually may be the result of bereavement overload.

Support. A person's ability to cope with loss can be affected by his/her support system. Social isolation makes adjustment more difficult. The death of a loved one, especially a spouse, is one of life's most stressful experiences. At no time since childhood is support so vital.

DISCUSS THE GRIEF PROCESS. After a person experiences a loss, certain tasks of mourning (or "grief work") must be accomplished for a person to obtain equilibrium in life. Worden outlines four basic tasks which must be completed:

1. To accept the reality of the loss
2. To experience the pain of grief
3. To adjust to a changed environment
4. To withdraw emotional energy from the "lost object" and reinvest it in another.

When the grief tasks are not completed, the individual's further growth and development can be impaired. "Successful grief work" or mourning requires (1) Time and (2) Effort on the part of the person experiencing the loss. Time alone does not heal.

Grief is a departure from the state of health and well-being. Mourning is a necessary healing process, similar to the healing that is necessary when a bone is broken. A person who is able to complete the "grief tasks," is once again able to function effectively. If the grieving process is blocked, the "healing" can be twisted and dysfunctional. Just as bones sometimes have to be reset, people sometimes have to go back and face their feelings again. Working through the grief at a later time is generally much more difficult. One reason for this is that the support people usually need to work through grief generally will be absent at a later date.

ACTIVITY. Ask study group members "What are some of the feelings or behaviors you have experienced when dealing with a loss?" or "What are some of the feelings and behaviors you have observed in people who have recently experienced the death of a loved one or another significant loss in their lives?"

List these on the newsprint. Emphasize that all of these feelings and reactions are normal. Then discuss in detail the four tasks of healthy grieving.

Task #1: Accepting the Reality of a Loss

The first task that a person faces following a significant loss is to accept the reality of that loss. When someone dies, even when the death is expected, there is generally the sense that the death hasn't happened.

The immediate response to the death of a loved one--particularly a young person or an unexpected death--is usually shock and denial, a belief that the death can't be true. A person may say, "He can't be dead--he still has so much to live for," "This can't be happening to me," or "She's only 17--there must be some mistake."

Most of us need a period of denial to mobilize our resources. Denial can serve as an insulation for cushioning the impact of the loss. The depth of denial may also depend on how much the person needs the "object of their loss" in order to function. The loss of an arm may be more devastating to a surgeon than the loss of a leg. The loss of a spouse may be particularly traumatic to a young woman with four children who has never worked outside the home.

The behavior of a person who just learns about a significant loss may seem irrational or inappropriate, but may be a part of his/her way of coping. An example is the woman who baked a cake after learning her brother had just died.

Denial may fluctuate with open awareness. Denial may remain in some form for months. There is no schedule for getting rid of it. Some people may find themselves beginning to set the table for the deceased several weeks later or talk about the person as though he/she is still alive. People need to be given adequate time and space to face the reality of their loss.

Viewing the body and the funeral itself often help many people to begin to face the reality of death, especially if the death was sudden. Touching the deceased may be a needed expression of love. However, none of these should be forced on an individual.

Some people refuse to believe that the loss is real and become stuck in the grieving process at the first task. They may deny the facts of the loss, the meaning of the loss, or that the loss (especially death) is irreversible. Professional help may be needed to help the person to become "unstuck" and to move forward in the grief process.

Task #2: Experiencing the Pain of Grief

To complete the grief work, a person must experience the pain associated with the loss. To cut off one's feelings and deny the pain hinders grief work. Painful thougnts must be faced. When they are not, the person may experience physical problems or display aberrant behavior--difficulties at work, problems in relationships, delinquent behavior.

Not everyone experiences the same intensity of pain or feels it in the same way, but it is impossible to lose a loved one without experiencing some level of pain.

Ways in which people keep themselves from accomplishing Task #2 include:

- Avoiding painful thoughts
- Avoiding all reminders of the lost object
- Becoming involved in frantic activity
- Using drugs or alcohol

128 Sooner or later people who avoid all conscious grieving, break down. Sometimes it is not the person who has experienced the loss who avoids grieving, but rather others who are uncomfortable with the mourner's feelings give the subtle message, "You don't need to grieve." For example, the teenager who has had an abortion may be encouraged to "forget about what has happened." Yet, in order to put the abortion in the past, the teenager may need to talk about what has happened and her feelings about it. Although the abortion may be a relief, there also may be feelings of loss associated with it.

If Task #2 is not completed, therapy may be needed later, at which time it may be more difficult for the person to go back and work through the pain that has been avoided. This is often a more complex and difficult experience than dealing with it at the time of the loss. Also, it can be complicated by having a less supportive social system that would have been available at the time of the original loss.

Acute grief includes many feelings, behaviors, thought patterns and physical sensations. Discuss some of these with study group members.

FEELINGS

Feelings experienced by the bereaved can be varied and sometimes confusing to the person. Feelings which are common and normal include sadness, loneliness, helplessness, yearning for the lost object, relief (especially common after the death of a person who has suffered a lengthy or painful illness), emancipation (particularly if the person lived under the tyranny of the person who died), anger, anxiety, and guilt.

Spend some time discussing anger and guilt in detail. These emotions are particularly confusing to the grief-stricken and to those people who are trying to help.

Anger. Anger and hostility are natural responses following a loss and may range from mild to rage. Unfortunately, the expression of anger is often denied. Anger may be directed towards:

- Doctors — "If the doctor only had come when I first called, maybe John wouldn't have died."
- God — "What kind of God would let this happen?" "How could a kind God take my husband (child, wife, etc.)? He was too good of a person to have died now."
- The deceased — "How could he leave me alone with all these debts....all these responsibilities."

  "A child may say, "I hate Mommy for leaving me."

Anger is particularly confusing for a survivor when it is felt toward the deceased. The person needs an opportunity to express the anger. The worst thing well meaning friends and family can do is to tell the person, "You shouldn't feel (or talk) like that." Bottled up anger generally will be expressed in negative ways: poor job or school performance, relationship problems, turning anger against oneself

or displacing the anger onto others. Sometimes it may seem that friends and family cannot do anything right for the bereaved. Friends and family may be rejected or treated like strangers. The person needs to be understood and given patience, even when rejecting others. Jensen in Healing Grief states:

> "Terrible grief demands a scapegoat. Even good relationships can suffer the stress from this anger."

Guilt. Feelings of guilt, regret and self-reproach are common. Guilt often results from the "if only" and "should have" thoughts.

- The person may search for evidence of their neglect or responsibility for the death or loss. Quarrels may be recalled. Focus may be on the times when the person was harsh, uncaring, had wished the person dead, or ways in which they might have prevented the death.
  - "Why didn't I go with him on the trip?"
  - "If I hadn't argued with him right before he left for work"
  - "If I had only forced her to go to the doctor when I knew she wasn't feeling well."
  - "I should have listened more carefully. Then, maybe I could have prevented him from taking his life."
  - "If only I hadn't wished him dead..."
- Sometimes feelings of guilt arise from a feeling of relief, for example, when a person dies after a long illness or a severely handicapped child dies.
- Feelings of guilt following a suicide often are the strongest and the most overwhelming.

Whether the person is guilty or just feels guilty is not the important issue. The point is that after a person dies, we no longer have the possibility of resolving those feelings directly with the person. The bereaved need an opportunity to express and work through their feelings of guilt; otherwise such feelings will be internalized and may produce neurotic or distorted grief reactions. To say, "You have no reason to feel guilty," without giving the person an opportunity to express and deal with his/her feelings, only inhibits the grief process.

Most guilt is irrational and will mitigate through reality testing. In Helping Grief, Jensen suggests an outlook which may be helpful to a person who feels his/her neglect contributed a person's death. Jensen says:

> "Ask yourself if you could have the person back, could you promise never to make another mistake? If the day you would like to change could be undone,

what about the next day? It might bring some other situation or some other failure, equally devastating"

For the person burdened by guilt, professional counseling should be considered. The person with a religious life base may find a clergyman helpful in dealing with guilt on a spiritual level.

Real guilt is difficult to work through and usually requires professional counseling.

Anxiety. Anxiety may range from a feeling of slight insecurity to panic. Anxiety comes primarily from two sources: (1) a fear of not being able to function witnout the person or lost object and (2) a heightened sense of one's own mortality.

Loneliness. Loneliness is one of the greatest problems experienced by the recently widowed. Family and friends often spend considerable time with the bereaved person during the first couple of weeks following the death, then the mourner is left alone. It may be at this time that the person really begins to feel the reality of the loss--an empty chair, an unused pillow, a family photograph, an extra toothbrush, a missing telephone call. Evenings and weekends can be particularly difficult and lonely times.

FEELINGS THAT EXIST FOR ABNORMALLY LONG PERIODS OF TIME AND AT EXCESSIVE INTENSITY MAY INDICATE A COMPLICATED GRIEF REACTION.

PHYSICAL SENSATIONS

- Hollowness in stomach
- Tightness in chest
- Tightness in throat
- Oversensitivity to noise
- Sense of depersonalization
- Shortness of breath
- Muscle weakness
- Fatigue, lack of energy

THOUGHT PATTERNS

Many different thougnt patterns mark the experience of grief. These include:

- Disbelief
- Confusion -- "Am I going crazy?"
- Preoccupation with image and thoughts of the deceased
- Sense that the person is present
- Visual and auditory hallucinations - waking up in the middle of the night and "seeing" the deceased at the end of the bed; smell the tobacco the person smoked; hear the person saying "everything will be all right."

BEHAVIORS

- Sleep disturbances -- difficulty going to sleep or awakening in the early morning; if persists, may indicate a more serious depression
- Appetite changes, especially loss of weight

- Absent-minded behavior
- Social withdrawal
- Dreams of the deceased
- Restless overactivity
- Searching and calling out-"Jack please come back": when not done verbally, it can be going on subvocally
- Sighing
- Avoiding reminders of the deceased--Generally, it is not healthy to quickly get rid of all the things associated with the loss.
- Crying--Tears have a potential healing quality; tears also relieve emotional stress
- Visiting places, carrying objects, or treasuring objects that belonged to the deceased.

Not all behaviors, feelings, thought patterns, and physical responses will be experienced by one person. Most important is that we understand the wide range of responses typical of normal grief, so that we allow their expression. We also can provide reassurance to those people who experience such feelings, behaviors, etc, and are disturbed by them.

Task #3: Adjusting to a Changed Environment

Adjusting to a new environment means learning to live without the loved one or the "lost object". It involves learning the skills that are now necessary to live life once again to the fullest extent possible. For the widow this may mean coming to terms with living alone, raising children alone, managing finances, learning to drive, etc. For the person who has lost the use of his/her legs it means learning to live from the wheelchair. Ways of maladjustment include promoting one's own helplessness, not develoing the skills needed to cope most successfully with the changes, and withdrawing.

Task #4: Withdrawing Emotional Energy From the Past and Reinvesting It

This phase of adjustment begins slowly. It's a time when the person begins to feel "it's time for me to move on." There is a sense of renewal, a reinvestment in oneself. Attention begins to turn outward again--new friendships may be developed, a trip may be taken, and previously enjoyed activities resumed or new activities undertaken. This is healthy and natural. Lynn Caine in Widow describes her recovery this way:

> "I wanted to taste life again. To live, to work, to love. Suddenly, I was impatient with my whole life... More and more I wanted to clear away the worries and problems. There were days when I felt more whole, more capable than I ever had in my whole life" (p. 151)
>
> "Acceptance finally comes. And with it peace... Today I am more independent. I have more understanding, more sympathy. I have a quiet love for Martin. I have passionate, poignant memories. He will always be a part of me...But Martin is dead. And I am a

> different woman. And the next time I love, if I ever do, it will be a different man, a different love." (p 222)

Anxiety and guilt are sometimes felt in the beginning. Guilt may be felt for again enjoying life, being happy or loving another. Some people feel if they withdraw their emotional attachment, they are dishonoring the memory of the deceased--or sometimes, others will give such messages to the person. Some individuals are afraid to reinvest their emotions in another relationship because they don't want to experience the pain of "losing again."

Encouragement, support, and permission to "live and love again" from family and friends can be particularly helpful. This can help people to let go of the past and start to live for the future.

This task is the most difficult for many people to accomplish. Setbacks often occur. Grieving is a circuitous process, not a straight shot ahead. Memories appear, emotions erupt, pain once worked through may be experienced again. This is normal and occurs throughout recovery.

A healthy recovery does not occur by pushing oneself or being pushed by others too fast in the recovery period. As with the advent of spring, crocuses and blue skies are seen, followed by snort frosts, clouds and rain.

THE GRIEVING FAMILY. Talk about the grieving family and how different family members may grieve in different ways or be in different phases of the grief process at one time. Emphasize the importance of each family member being able to grieve in his/her own way.

Depending on the needs and desires of your study group members, you may want to discuss children's reactions to death and what can be done to help children deal with grief. Refer to the bulletin Death a Family Crisis, PNW 88, for information.

Every individual has his/her own style and pace for dealing with death. Therefore, each member of a family is likely to grieve differently. It helps if family members can understand and accept these differences. One person may deny the death, another be angry at the deceased, another depressed, and another accepting of the death. Such differences in response and timing can lead to communication problems in families:

> "Look at Sarah--so cool and collected. She doesn't really care that Mom died. Doesn't she have any feelings?"
>
> "Stop being so hysterical and melodramatic. We've got business to take care of."
>
> "You mustn't cry. You need to be strong for the rest of the family."

Families who are aware of the variety of grief reactions are better able to deal with their own responses.

In the death of a child, the anticipated ideal of each spouse supporting the other is rarely realized. Neither husband or wife is in a position to be leaned upon.

The family is seen in our culture as the center of support. Many families, however, are ill-prepared or lack the resources to help their individual family members journe through the grief process. For that reason alone, death is not just a nuclear family affair. It is appropriate to draw on friends and the extended family to help us through our grief.

ADDITIONAL FACTORS AFFECTING GRIEF. In your discussion, you may want to bring in information about the following factors which may relate to a person's grief: Anticipatory Grief, Beliefs and Misconceptions, Faith, Culture and Rituals, and Anniversaries.

Anticipatory Grief. In going through a long dying process with a loved one, a great deal of the loss and grief may be experienced before physical death occurs. The death even may bring a sense of relief, especially if the person was in severe or prolonged pain. One older man said a few hours after the death of his wife, who had been terminally ill for several months, "the knot in my stomach is finally gone. It's a relief for her and me that she is no longer suffering."

Beliefs and Misconceptions. Our beliefs about death and grief influence our bereavement. While certain beliefs can ease sorrow, others can make the resolution of grief more difficult. Beware of some common misconceptions:

- I'll never get over this. I can (or should) never love again. To honor the deceased, I cannot enjoy life.
- The degree of a person's suffering indicates his/her love for the deceased.
- If I allow myself to feel, I'll never pull myself together.
- It is a sign of weakness to cry.
- Repressing my feelings indicates courage.

It is often helpful to closely examine one's feelings and beliefs about death and grief and how they developed. Questions to ask oneself which may be helpful include:

- What did I learn about grief from my family?
- What are my beliefs about death?
- What was my first experience with death? How did I handle it?
- What was my first experience with a significant loss?

Faith. Researchers in death and dying find that faith is a powerful tool in coping with loss. The person with spiritual roots is likely to pass more easily through the process of grief.

Culture and Rituals. The approved manner and duration of grieving varies from culture to culture and between families. The public aspects of grieving--for example wearing black for a year or holding a festive gathering--originally were designed to help the bereaved come to terms with their loss and get support from the community. In cultures where rituals for the dead are established, the role of the mourner often is easier. Rituals can help us to resolve our feelings. In our fast-paced,

mobile lives, it is important for individuals to discover the rituals most helpful and fitting to them.

Anniversaries. Special holidays previously shared with the deceased often stimulate grief. A holiday, birthday, wedding anniversary, or family gathering can heighten awareness of the loss. Festive occasions, especially shortly following a death, are often difficult because of the expectation that we "should" be happy, "should" be having a great time. The contrast between those "shoulds" and actual feelings often increase the pain. The "shoulds" need to be banished. It often helps if the person can plan in advance something to do that provides nourishment and comfort. This may be following family traditions or doing something novel.

The anniversary of the death of a loved one--especially the first anniversary--is often painful. Anniversary grieving is to be expected and marks another step in the journey from loss to renewal and integration.

HELPING THE BEREAVED. Draw on study group members experience and discuss (1) the feelings and difficulties they experience in relating to the bereaved and (2) Ways in which others can be helpful to the person experiencing grief.

You may want to begin this section by saying something like the following: "If you have ever known a grieving person, you probably remember your own feelings of awkwardness, discomfort, and confusion. What should I say? How should I act? Should I leave the person alone? Should I prevent her from being alone too much? Should I try to cheer him up? Is it okay to talk about the death or should it be avoided?

Close family members can be just as bewildered as friends and acquaintances about how to relate to the bereaved. A principal task is to provide emotional support and to empower the person and not produce a sense of helplessness and incompetence. How can we do this?" Discuss some ways to help the bereaved.

Suggestions for helping the grief-stricken may include:

- Communicate your caring and support. This can come in the form of your presence, telephone calls, a caring touch, letters, providing child care, preparing a meal, notifying others of the death, and activating a network of support.

- Be a good listener. Allow the person to talk about the loss. People often need to go over and over the loss before they can accept it. Allow silences. The person may need time to say what is difficult to say. Most important as a listener is to accept the grieving person "where he/she is at."

- Help person to identify and express feelings. Accept expressions of hostility and anger. Do not react to such emotions with counter-hostility or take them personally. Provide reassurance that such feelings are normal.

- Take the initiative. Ask, "When can I visit?" and "How can I help?" The grieving person usually finds it difficult to ask for help.

- Give the person time. Expecting unrealistic, rapid adjustments can push the individual into a depression.

- Continue to be available and involved throughout the grief process. The bereaved need support, especially after the shock and numbness have worn off. The bereaved person may be too exhausted to make contact or may not want to burden you. Call. Invite the person to do something with you. Set a date. Vague invitations, such as "Let's get together sometime," usually don't help.

- Share your feelings. Expressing your sadness and sorrow can make the bereaved person feel understood and reduce the sense of isolation. Offer advice only when asked.

Some DON'T'S to avoid include:

- Don't assume a particular belief system about death and after-life. Don't push your values or beliefs onto the bereaved.

- Don't offer cliches and false reassurances such as "time heals all wounds." That is like telling a starving man he will eat--someday! A hug or even saying "I don't know what to say to you" is better than ill chosen words.

- Don't discourage the expression of feelings. Discouraging expression of emotions can prolong the grieving process.

- Don't say, "Iknow what you're feeling." You cannot know their unique experience.

- Don't give up. Make sure your efforts bypass the first "no thank you", "I'm managing fine," "there's nothing anyone can do." At the same time. respect the bereaved person's privacy and personal boundaries. Sometimes the bereaved person needs to shut other people out.

HELPING MYSELF WHEN EXPERIENCING GRIEF. Ask study group members, "What can we do when we are the bereaved person? How can we help ourselves? In many ways it is easier to help others than oneself. Not only does one have to work through his own grief, which is often overwhelming, but also many tasks need to be completed and decisions made." Talk about the following:

- Avoid major decisions. Good judgement is difficult to exercise during acute grief. Generally it is better to work through grief in familiar surroundings.

- Give yourself time and space to grieve. Great emotional investments are not easily made, nor are they easily lost. Pushing feelings aside is not a long-term solution.

- Take care of yourself. Eat well, exercise regularly, rest. Grief can be a threat to health, even life. Research shows that people experiencing a significant loss, particularly the loss of a loved one, are more likely to become ill themselves within six months of the loss. This is a time when a person may be accident prone and more vulnerable to contagious illness.

Somatic responses are common with grief. Over 75% of patients with ulcerative colitis develop the disease shortly after the loss of someone close. Rheumatoid arthritis, asthma, migraine headaches, bronchitis, spastic colon are frequently linked with grief. One study showed that three months after the death of a spouse, widowers had a 50% greater chance of having a heart attack.

- Avoid alcohol and drugs. These substances can prevent grieving and inhibit the natural healing process. If medication becomes more than a temporary measure to help a person though the initial grief, professional counseling should be sought.

- Accept your grief and pain. Do not try to be "brave." Take the time to cry.

- Build on your memories. Though you must accept your loved one's death, you need not sever all ties. Memories can be used to establish a new relationship and to enrich your life. Recall the good times, the humorous times.

- Actively work through your grief. Realize that time alone does not heal.

- Get professional help if needed. Do not allow crippling grief to continue. There comes a time to stop crying and to live again. Sometimes just a few sessions with a trained counselor will help to resolve the anger, guilt , despair, or other feelings that keep a person from functioning.

Jensen in Healing Grief states, "Whatever you do, do not waste your life on unproductive sorrow. The best memorial to a loved one is a full, growing life."

CONCLUSION: To conclude this lesson, you may want to read the following poem, "But it Hurts...Differently"

There is no way to predict
how you will feel

The reactions of grief are
not like recipes,
with certain ingredients,
and certain results.

Each person mourns in a
different way.

You may cry hysterically,
or
you may remain outwardly controlled,
showing little emotion.

You may lash out in anger against
your family and friends,
or
You may express your gratitude
for their concern and dedication

You may be calm one moment--
in turmoil the next.

Reactions are varied and
contradictory

Grief is universal.
At the same time it
is extremely personal

Heal in your own way.

Prepared by: Vicki L. Schmall, Ph.D.
Gerontology Specialist
Extension Service
Oregon State University

September 1983

CONCEPT #5: COMMUNICATION SKILLS

Objective 5.1: The student will describe changes in hearing and vision that may occur with age.

Generalization:

As we age, changes occur in vision and hearing. These changes are particularly important because they affect a person's ability to function in the physical environment and in social interactions. Most older adults have adequate vision despite common age-related changes. However, many older adults experience farsightedness (presbyopia) or an inability to focus on near objects; decreased ability to perceive contrasting boundaries and to focus in low light levels; decreased ability to adapt quickly to change in light levels; and decreased ability to perceive cool (blue and green) colors; and increased sensitivity to glare.

Older adults compensate for most of these normal age-related vision changes. Increasing light levels allows the average 75-year-old to perceive light as well as the average 25-year-old. Use of high color contrast and warm (red, yellow) colors compensates for the yellowing lens. Other compensations include avoiding situations that demand sudden adaptation to changes in light levels (such as night driving) and using magnifying and/or prescription lenses. These environmental and behavioral changes enable most older adults to adapt well to the common age-related changes in vision.

The auditory sense also declines with age. Estimates vary, but probably 60% of the elderly suffer some hearing loss. Much of this loss is not the result of aging, but rather the consequence of prolonged environmental noise and chronic ear infections. The most common hearing loss is presbycusis. This loss is probably the result of the loss of cells in the inner ear where sound waves are transformed into nerve impulses. The cells which perceive high frequencies (2000 cycle/second) are the most susceptible to loss, thus high frequency hearing loss is common. This high frequency loss results in an inability to hear particular sounds, particularly consonants or consonant combinations (for example, c, ch, s, sh, p, z). People with this type of hearing loss often feel other people are mumbling. "Conductive loss" occurs when sound waves are not properly conducted through the outer and middle ear. Conductive loss results in a decrease in the volume heard. Some people experience both conductive loss and presbycusis. By understanding and responding to hearing problems, we can greatly aid communication with the hearing-impaired person.

Strategies and Resources:

1. Use the Pacific Northwest Extension Publication "Growing Older: Sensory Changes" to guide a simulation and discussion (resource section 5.1).

2. Read and discuss the Oregon State University Extension Bulletin (PNW 196) "Growing Older: Sensory Changes" (resource section 5.1).

Objective 5.2: The student will demonstrate effective skills for interacting with the hearing-impaired.

Generalization:

At any age hearing loss can result in diminished social interaction for the hearing-impaired. Communicating with the hearing-impaired requires special skills, but these skills can be learned by anyone. Because presbycusis (the inability to hear particular high frequency sounds) is the most common form of hearing loss, shouting does not usually help. Shouting tends to raise the voice sound frequency, and thus does not facilitate hearing. Hearing comprehension can be increased by speaking distinctly, facing the hard-of- hearing person, using visual aids, eliminating background noises, and repeating and rephrasing sentences.

Strategies and Resources:

1. Use the Oregon State University Extension Service Leader-Teacher Guide for activities and discuss points to be used with this objective. (Attached to objective 5.1)

2. Have a hearing-impaired person talk with the class about communication techniques that facilitate hearing.

3. After doing strategies 1 and 2, have students role-play interactions with the hearing-impaired, demonstrating good techniques for communication.

Objective 5.3: The student will analyze living environments to assess their support for the visually impaired.

Generalization:

Home and other physical environments can be made significantly safer and more functional for the visually impaired. Raising light levels, establishing multiple sources of light, and creating contrasting surfaces are all techniques for improving the environments for the visually impaired.

Strategies and Resources:

1. Read "Growing Older: Sensory Changes" (PNW 196 - resource section 5.1) and "Housing the Elderly" (Journal of Home Economics, 1978, 71: 23-25 - resource section 5.3). Discuss the characteristics of supportive physical environments.

2. After completing strategy 1, evaluate a living environment to determine the accessibility for the visually impaired. Use a home and/or a community building. To help the students with the project have them work with a partner, blindfold each other (one at a time), and walk or simulate a mobility handicap, through the facility. Record their findings and their specific suggestions for improving the environment.

Objective 5.4: The student will demonstrate effective communication skills for interacting with people of all ages.

Generalization:

Skills in active listening, empathy, and interviewing are fundamental components of effective communication. Utilizing these skills in interacting with older persons can result in a mutual sense of worth and create a stronger relationship.

Strategies and Resources:

1. Discuss the reading, "We all want to be listened to" (resource section 5.4). Discuss these points:
   a. Is listening the same as hearing? If not, how are they different?
   b. Would you say that most people are good listeners?
   c. How would you know when the person you're talking to is listening carefully? How do you know when the person is not really listening? How do you feel when you know you are not being listened to?
   d. Do you regard yourself as a pretty good listener? For what reasons?

2. Using case studies, have students role play situations demonstrating such communication skills as reflective listening, "I" messages, body language, etc.

Objective 5.5: The student will describe the role of reminiscence in people's lives.

Generalization:

Reminiscence is an important part of everyone's life at all ages. Through stories about our past, we create and maintain our sense of personal identity and self-esteem. Young children often love to hear stories about themselves as babies and adults of all ages think and talk about the past.

Reminiscence is also an important part of older people's lives. Mental health professionals believe that reminiscence can enable a person to cope with current difficulties, maintain self-esteem, and find meaning in their lives.

Reminiscence also forms the basis for family and cultural oral history. As such, reminiscence has great value not only for the person reminiscing, but for families and friends who can learn and be enriched by one's life stories.

Strategies and Resources:

1. Have students read and discuss the article, "I remember when--the importance of reminiscing" (see resource section 5.5). Discuss the students' own important memories or "reminiscences."

2. Sponsor a "Nostalgia Day." Invite local senior citizens to bring an antique or anything that is no longer commonly used. Ask older persons to share stories about the item which they have brought.

3. Have students review "A Family History Questionnaire" (resource section 5.5) and select questions from the questionnaire to be used to interview an elderly relative or acquaintance. Students will then incorporate this information into a short biography of that individual.

   An alternative method would be to tape or record the interview on videotape to present to the class. Assemble all histories collected into an anthology to share with all people interviewed and the class members.

4. Encourage students to reminisce about their early years and write a short essay related to their early school years, trips or vacations they remember when they were younger, favorite experiences with relatives and friends, or other experiences.

Growing Older: Sensory Changes

The efficiency of the sensory organs—vision, hearing, taste, smell, and touch—declines with age, but the age of onset and the rate of decline differ markedly among people. A sensory change can affect an older person in a number of ways. Changes can be made in the environment to ease a person's adjustment. This publication is addressed to those who care for the elderly—to explain the sensory changes older people encounter and to suggest what you can do to help.

What is it like to hear only a mumbling voice when someone speaks to you? How does it feel to have poor vision and no longer be able to read a newspaper or book? Why do some older people complain that food doesn't taste as good as it did when they were younger?

As people age, they experience changes in the sensitivity of their senses—vision, hearing, taste, smell, and touch. Although most older people function very well, such changes affect daily living. They may mean reduced mobility, increased dependence on others, inaccurate perception of the physical and social environment, reduced ability to communicate with others, frustration, difficulty in accomplishing tasks or not being able to do them at all, and not feeling good about oneself.

All of us should recognize that age-related sensory changes occur, in varying degrees, but if you have elderly family members or if you work with elderly persons it is especially important to understand the changes that are likely. If you lack knowledge and understanding, you may find yourself becoming frustrated easily, setting unrealistic expectations, or mistakenly labeling an older person—particularly the hearing impaired—as "senile," "confused," or "failing." Understanding these changes should increase your ability to provide positive support and to make changes in the environment that enhance the life of an older person. You probably will find yourself focusing more on what a person can do and less on what the individual cannot do.

What are the sensory changes commonly associated with growing older? What do these changes mean to the older adult and to you?

Changes in Sensory Organ Function

The sensory receptors become less efficient with age; therefore, older adults generally require higher levels of stimulation if their sensory receptors are to perform with a sharpness nearer that of younger people. Age, however, is not the only factor causing deterioration of the sensory organs. Disease and environmental factors are also important. Intense and prolonged noise affects hearing, smoking often reduces taste and smell sensitivity, and accidents may injure the eyes.

The changes in vision and hearing are particularly important because they affect not only the person's ability to function in the physical environment, but also may create isolation.

A Pacific Northwest Extension Publication

Oregon • Washington • Idaho

Vision

The majority of older adults have good to adequate vision, but several aspects of vision do change with age. These changes include decreased visual acuity (sharpness), farsightedness, changes in color perception, decreased sensitivity to light, and decreased ability to adapt to glare.

Acuity

The most common change is a decrease in the ability of the eyes to see as clearly as when the person was younger. Visual acuity is generally at its maximum in the late teens, remains fairly constant until age 45-50, and then gradually declines. The Center for Health Statistics reports that by age 65, one-half of all people have a visual acuity of 20 70 (what can be seen at 20 feet, a person with perfect vision can see from 70 feet) or less, while fewer than 10 per cent of people 45 and younger have vision poorer than 20/70. In a survey by the National Optometric Association, one-third of those older than 65 reported that an inability to see well prevented them from doing things they wanted to do. More than half of all the severe visual impairments occur in people 65 and older.

Farsightedness (Presbyopia)

With age, the lens of the eye diminishes in its ability to see close objects. This change often becomes noticeable during the 40's and 50's, when it is not unusual to hear people say, "My arms must be growing shorter, I can't hold the paper far enough away to read it." Although bifocal lenses help, many older people still find it difficult to see small details, such as the hole of a needle, directions on medications, or numbers in a telephone directory.

Color perception

Several studies suggest that the lens of the eye yellows with age and filters out colors at the blue end of the light spectrum. As a result, an elderly person may not be able to discriminate between shades of blues and between blues, greens, and violets. For example, a 90-year-old nursing home resident could not see the blue flowers in a bouquet because the blue blended into the green leaves. An older person's outfit of different shades of blue may look poorly coordinated to a younger person, but to the older individual the colors may look the same. It is important not to interpret an inability to identify colors as a sign of confusion. Colors more easily distinguished by older adults are the yellows, oranges, and reds. For both pleasure and safety, these colors should be kept in mind when developing printed materials and painting or redecorating the environments of older adults.

Decreased sensitivity to light and increased sensitivity to glare

The eye decreases in its ability to adapt to changes in light level. An older person entering or leaving a darkened room usually requires more time to adjust to the changes in light levels than a younger person. Abrupt changes can be hazardous and cause falls or other accidents. Night lights in bedrooms and bathrooms and a consistent light level in both bedrooms and hallways help prevent accidents. Many older people prefer daylight driving because they experience momentary blindness and glare at night from lights of oncoming traffic and reflections from wet pavement.

Increasing age usually is accompanied by increasing dependence on good lighting to see effectively. Brightness of illumination usually must be increased 50 per cent at age 50, 100 per cent more at age 60, and another 33 per cent at age 80 to achieve the levels of visual sharpness, contrast, and reading speed present at age 20. In poor lighting, an older person may not see potential hazards or recognize familiar people.

When increasing light levels, distribute the light evenly and minimize glare. Older adults experience an exaggerated amount of glare from an intense light source. Glare that is hardly noticeable to a younger person may create difficulties for the older person. Shiny surfaces that produce glare need to be avoided in planning an environment.

Other age-related eye changes

Older people often experience cataracts, glaucoma, and macular degeneration. Cataracts are the most common disability. The lens of the eye changes from clear and transparent to cloudy and opaque resulting in distorted vision. It is said that everyone would develop cataracts eventually if they lived long enough. Surgery is nearly always successful in correcting visual losses caused by cataracts.

Glaucoma is less common, but is more serious than cataracts and can cause blindness. Glaucoma is caused by an abnormally high pressure in the eye, a condition created when the fluid that bathes and nourishes the eye cannot drain out of the eye and places pressure on the optic nerve. It is the "sneak thief of sight" because there are few early symptoms. If undiagnosed and untreated, glaucoma eventually can lead to blindness. Today early diagnosis and treatment can slow or prevent much of the vision loss. Preventive care is vital. Simple, painless checks for glaucoma should be performed annually on people past age 50. Persons with a family history of glaucoma should be particularly concerned with annual checkups. Glaucoma is usually treated easily and effectively with medication. Minor surgery to allow fluid drainage is sometimes necessary.

Nearly 30 per cent of the aged have some degree of macular degeneration, a condition that

causes loss of central vision. Peripheral or side vision is not affected. The macula, an area 3/16 of an inch diameter in the retina, enables us to see fine details. When the macula is damaged, the person is able to get around by himself particularly in familiar surroundings, but often is unable to read, enjoy television, or identify people until they are close. Low-vision aids help a person to use remaining vision more effectively and efficiently. Treatment is largely concerned with prevention or slowing the progress of the disease by medical treatment.

Although most older people will have some loss of vision, many retain near-normal vision well into their seventies and eighties. However, persons with losses in vision may experience decreasing mobility, poor orientation, and frightening visual impressions that resemble hallucinations. Reading, watching television, and other pastimes may be reduced or eliminated. Older adults also generally feel more vulnerable to danger and crime when handicapped by vision and other sensory losses.

What can you do to help?

What can you do to help the visually impaired function more effectively in their environment? Techniques, in addition to those previously discussed, include the following:

- Use good contrast between the background and lettering of printed materials. Paper should have a dull finish and large lettering should be used.
- Obtain large-print books or "talking" books for the severely visual impaired who enjoy reading. Information about such books is available from state and local libraries.
- Use contrasting colors, for example, between doorways and walls, dishes and tablecloth, and the risers and flat surfaces of steps.
- Use coding schemes, for example, color or dots of glue at different points on oven and washing machine dials can make different dial settings easier to find and, consequently, enhance independent living.
- Simplify the visual field and avoid clutter, but don't change the location of objects without the person knowing about it.
- Give pre-warnings when approaching or moving the visually impaired. Otherwise, you may unintentionally frighten the person. Let the individual know what you are going to do. This gives advance information about actions and helps the person to feel more secure.
- Use touch to enhance communication. Holding or patting someone's hand can tell the person where you are and that you are listening and have not walked away while the individual is talking.
- When entering a new environment with a visually impaired person, explain the people present, and their location.
- When walking, let the visually impaired person take your arm just above the elbow. You will be walking a half step ahead. The person can better anticipate your movements and generally feels more secure than if you grab his arm.

Hearing

Hearing loss is potentially the most serious of the sensory impairments. Unlike poor vision, hearing loss rarely inspires sympathetic understanding. The seeing eye dog, thick glasses, and white cane all help us to identify the blind and visually impaired, but the hard-of-hearing and deaf are not as visible. In regard to her deafness, Helen Keller stated:

> "I am just as deaf as I am blind. The problems of deafness are deeper and more complex, if not more important than those of blindness. Deafness is a much worse misfortune. For it means the loss of the most vital stimulus—the sound of the voice that brings language, sets thoughts astir, and keeps us in the intellectual company of man —"

Hearing loss affects more people than any other chronic condition. From age 20 to 60, the rate of hearing impairments rises from 10 to 75 per 1,000 population. Between the ages of 60 and 80, the rate increases to 250/1,000 population. Approximately 30 to 50 per cent of all older people suffer a significant hearing loss that affects their communication and relationships with others. Older men usually have a greater hearing loss than older women. This is probably due to the fact that more men have worked in noisy jobs.

Hearing loss can lead to other problems. It can cause isolation, anxiety, and depression. Even a slight loss can be emotionally upsetting, particularly if it interferes with correctly understanding the television, family, and friends. Many people will withdraw from group situations when it becomes a chore to listen and to follow rapid topic changes in conversation. Travel by public transportation can be difficult, particularly if announcements over the intercoms are unclear. Furthermore, loss of hearing often occurs at a time when a person is adjusting to other age-related losses, including perhaps death of friends and loved ones. A hearing loss may complicate adjustment.

Types of hearing loss

The two general categories of hearing loss in the later years are conductive loss and sensory-neural loss. With conductive loss, sound waves are

not properly conducted to the inner ear. All sounds seem muffled. The cause may be an obstruction in the outer ear—an accumulation of wax, or a blockage caused by swelling and pus—but, more often it is a problem in the middle ear.

In sensory-neural loss, the sound waves reach the inner ear, but are not properly converted into a message that can be passed on to the brain. The sensory-neural loss associated with the aging process is called *"presbycusis."* The person with presbycusis generally hears low-pitched tones, but the high-frequency sounds of speech are distorted. The vowels, such as "a," "e," "i," "o," and "u" are low-pitched sounds; the consonants, such as "th," "s," "sh," "f," and "p" are high-pitched sounds and more difficult to hear. As a result, the person has difficulty discriminating between words that sound similar and consequently has difficulty following a conversation. For example, to a person with presbycusis, fifty and fifteen cents may sound the same. The individual may hear "dead" when you say "bed"; "choose" instead of "juice"; or "fill" for "pill." High-tone loss is universal in old age, but there are marked differences in the degree of loss.

Reactions to hearing loss

Many older people are not aware of the degree of their hearing loss, particularly if the loss has been gradual. Others have difficulty admitting they have a hearing loss, particularly if they equate hearing loss with inadequacy.

Persons with hearing impairments may:

- Speak unusually loudly or softly; their voice may sound monotonous or have an unusual quality.
- Accuse others of mumbling and not speaking clearly.
- Position their head to facilitate hearing.
- Ask a speaker to repeat what has been said.
- Fail to follow directions or to respond to sudden sounds or verbal messages.
- Give inappropriate responses to questions.
- Withdraw from social participation and become increasingly isolated.
- Be distracted easily. Attention span often becomes shorter and the individual usually requires more time to respond to verbal messages and other stimuli.
- Display paranoid behavior, being suspicious of others and what they are saying.

It is important for you to recognize that such behaviors may indicate a hearing loss. Too often, older hard-of-hearing persons who appear confused or give inappropriate responses are labeled as "senile," "stubborn," "dull," "bizarre," and the hearing loss is not diagnosed. The older adult with a hearing loss should be referred to a physician who specializes in hearing problems (otologist/otolaryngologist) and can identify any medical problems and then to an audiologist or speech and hearing clinic for an audiological examination.

Hearing aids

An audiological examination will determine if a hearing aid can help and to what extent. A hearing aid seldom restores normal hearing and it cannot help some hearing losses. Some evidence suggests that older persons are less likely to obtain satisfaction from hearing aids than other age groups.

Although a hearing aid often enhances social participation, many older persons find hearing aids annoying, because not only is the sound of the human voice increased, but *all* sounds are amplified. Sounds may be heard that have not been heard in years.

A period of adjustment is required to learn to use a hearing aid. Sometimes family members and others who work with older adults make a mistake of encouraging older people to wear their hearing aids initially at the wrong times—for example, in noisy situations such as the dinner table when everyone is talking and pots and silverware are clanging. The loudness of so many new sounds may be disturbing and make it difficult to learn to discriminate speech with the hearing aid. Wearing an aid for only a short time (15 to 60 minutes) during a quiet time of the day and gradually increasing the time over a month to 10 to 12 hours a day makes the adjustment easier. It is important to take proper care of a hearing aid to ensure its effectiveness.

The proper fitting of a hearing aid may require several visits to an audiologist for adjustment of the sound range being amplified. Patience and practice will result in a hearing aid becoming a real tool in restoring communication.

What can you do to help?

Communication skills which are often helpful include the following:

- Speak clearly in a moderate voice.
- Do not shout. Shouting creates a booming effect and makes it even more difficult to hear. Shouting only accentuates the vowel sounds and obscures the consonants. This is especially true when speaking to someone with a hearing aid.
- Lower the tone of your voice, particularly if it is high pitched.
- Get the attention of the hard-of-hearing person before speaking.
- Face the hard-of-hearing person directly and on the same level whenever possible. Keep hands

away from face. Many hard-of-hearing rely partially on lipreading to get a message. For the person with both a vision and hearing problem, communication problems are increased.

- Position yourself so that light is shining from above or toward you, rather than from behind into the eyes of the hard-of-hearing.
- Use facial expressions, gestures, and objects to further illustrate the verbal message.
- Speak slowly and distinctly, but do not exaggerate lips. Overarticulation distorts the mouth and what is being said.
- Remove objects from your mouth when speaking, for example, gum, cigarettes, and food.
- Allow longer intervals between sentences. It often takes the older, hearing-impaired person longer to absorb and understand a message.
- Decrease background noises when talking with the hearing-impaired. Turn off the radio and television.
- When giving important instructions to the severely hearing-impaired, write them down as well as give them orally.
- If a person has greater loss in one ear than in the other, direct your conversation toward the "good" ear.
- If a person has difficulty understanding what is being said, use different phrases with similar meaning.
- Try to become aware of acoustical problems in the room or area, and make adjustments to improve speech perception by the hard-of-hearing.
- Keep your voice at about the same volume throughout a sentence.
- Ask the hard-of-hearing person what you can do to help understanding.

When playing music for hard-of-hearing older people, adjust the sound system so lower tones are predominant. Organ music is often popular because of the richness of the lower tones.

Taste

Food that tastes and smells good is important in maintaining a good level of nutrition. However, with increasing age the senses of taste and smell decline and can affect the pleasure and satisfaction older people obtain from food. The number and sensitivity of the taste buds decrease, but these changes usually do not seriously affect taste sensitivity until the seventh decade of life.

Most people over the age of 65 have lost 50 percent of their taste buds. By the late 70's, the average person has one-sixth of the taste buds of a 20-year-old.

Factors other than age, such as smoking and poor mouth and dental hygiene, also affect ability to taste foods.

After the age of 50, the ability to perceive the four taste sensations—sweet, salty, bitter, and sour—decline, but not at the same rate. Studies indicate the taste receptors that identify sweet and salty flavors are the first to atrophy, while those that sense bitter and sour flavors tend to function well into old age.

The older person who has experienced changes in his ability to taste food may reminisce about how much tastier food was when he was young, implying that foods were different and better then. He may quit eating because "nothing tastes good" or he may eat excessively attempting to achieve some taste sensation. A common complaint is that "the food just doesn't taste right," or "this food tastes sour or bitter." As a result, an older adult may put excessive amounts of sugar, salt, or seasoning on his food, which may ruin the flavor of food for a younger person.

Older people who have poor vision and have lost their taste sensitivity often find it difficult to identify foods. Food may have little appeal to them. Diet restrictions, for example bland or low-salt diets, can contribute further to the undesirability of food. Poor health, low physical energy, not wanting to prepare a meal for just one person, and limited budgets also contribute to some older people not eating well.

To encourage eating, food should be prepared and served attractively. Distinctive and varied textures, colors, and temperatures add to the identification and enjoyment of food. Food may need to be more highly spiced. The older person who chews food well and switches from food to food when eating obtains more taste from food, and hence more enjoyment from a meal.

If the person needs assistance with feeding, avoid mixing foods together because such mixing makes it impossible for the individual to separate flavors. Encourage good dental and mouth hygiene.

Smell

Many older people have difficulty identifying common foods and environmental substances by smell. The exact mechanism for this decline is not known; however, studies indicate the sense of smell may be the earliest sensory system to decline with age, beginning as early as the late thirties or early forties.

Because two-thirds of the taste sensations depend on the ability to smell, decline in the smell system may further depress an older person's appetite or interest in food. Loss in the ability to smell may mean an individual can no longer smell body or household odors that may be offensive to others. Warning odors—smoke, gas, or spoiled

foods—may be undetectable. Smoke alarms and pilot lights can decrease the potential hazards that loss of smell creates—especially for persons living alone.

Adding artificial odors to food is one method of improving food flavor for some older persons. For example, artificial green bean odor can be added to green beans and artificial potato odor and flavor added to potatoes. Adding such odors will not be helpful to older adults who have completely lost their sense of smell, but may help some older people enjoy their food more. Artificial odors are manufactured by several companies, including Furmenich, 277 Park Avenue, New York, N.Y. 10017, and International Flavors and Fragrances, 1515 Highway 36, Union Beach, N.J. 07735. The companies may be able to direct you to local distributors or sources. The Extension Service lists these addresses as a service, and does not endorse these products over others that may be available.

Foods with artificial odors added may be aversive to young people or others who do not need them.

Touch

Although research is limited, studies suggest an age-related decline in the sensory system of touch. Skin sensitivity and the ability to detect pain decreases. It becomes more difficult for the person to distinguish textures and objects on the basis of touch alone. A person may not recognize he is being touched or may have a delayed reaction.

Pain threshold increases. As a result, an older adult is more likely to be burned or cut and not know it until severe damage has occurred. The hot temperature of bath water or a heating pad, for example, may not be readily felt. An older person also is less likely to perceive internal body pain or a rising temperature as early as a younger individual. This may result in an illness progressing to an advanced stage before detection. This is particularly common and potentially dangerous in the older diabetic. Because diabetes contributes to loss of nerve sensitivity and blood flow in the feet and legs, severe cuts and bruises may not be noticed and severe infection may result.

For all persons over 70, precautions such as lowering the temperature of a hot water heater help to reduce the likelihood of accidents due to decreased touch and pain sensitivity.

The use of touch can be a powerful therapeutic tool. Yet, evidence suggests that many older adults are touched very little or not at all and suffer from "touch hunger." Touching has a number of advantages. It is a powerful means of communication, it can help make up for loss in other senses, reduce anxiety, and provide comfort. However, when using touch, it is important to consider the older person's background, culture, and sense of private space. A simple handshake or pat on the back can communicate warmth and respect to the older person.

Your Attitude is Important

When working with sensory-impaired older people, keep in mind that personality, life-style, and family and friends affect their adjustment. Many compensate well for their losses. Others may use their loss as a means of getting attention. Those who are proud—and afraid of losing their independence—may refuse help. Your attitude and response toward the old and the handicapped is a key to being an effective helper. Try to avoid distorting a single handicap into a total handicap, and treating the older handicapped individual with a patronizing attitude. Instead, be helpful, while enhancing the elderly person's feelings of adequacy and self-esteem.

This publication was prepared by Vicki L. Schmall, Extension gerontology specialist and assistant professor of family living, School of Home Economics, Oregon State University. It was reviewed and approved for use by the Extension Services of Oregon, Washington, and Idaho.

PNW 196 MARCH 1980

Published and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914, by the Cooperative Extension Services of the University of Idaho, James L. Graves, director; Washington State University, J. O. Young, director; Oregon State University, Henry A. Wadsworth, director; and the U. S. Department of Agriculture, cooperating. Extension programs are available to all people without regard to race, creed, color, sex, or national origin.

Oregon State University
Extension Service

HE 13-001L
Reprinted August 1982

LEADER - TEACHER GUIDE

GROWING OLDER: SENSORY CHANGES

PRIOR TO LESSON

1. Read the bulletin, Growing Older: Sensory Changes. Familiarize yourself with the suggestions about how to help older people with various sensory problems.

2. Read the leader-teacher guide thoroughly before making or obtaining materials. Several activities are suggested for each simulation; however, time may not allow you to conduct all activities. Therefore, you will want to select those activities most appropriate for your group.

3. Obtain or prepare the following materials:

FROM THE COUNTY EXTENSION AGENT:

- Copies of the bulletin, Growing Older: Sensory Changes for each group member
- The cassette tape, "The Unfair Hearing Test"
- Copies of the Crossword Puzzle and Application Form for each group member (if you decide to use these)

FOR IMPAIRED VISION:

- Make cellophane eye covers for each group member. Fold cellophane or plastic wrap two or more times so that vision is partially impaired. After folding, crinkle the cellophane. (If available, yellow cellophane is the most effective.)

FOR EACH PARTICIPANT:

- A square (4"x4") of cloth, needle with a fairly small eye, thread, a button, and a pencil
- Optional: telephone books, empty prescription bottles, newspapers, or magazines

FOR IMPAIRED HEARING:

- For each participant, a sheet of paper and a pencil
- Cassette tape player

FOR IMPAIRED TOUCH:

- For each participant, one pair of latex or surgical gloves. (You may want to ask participants to bring a pair of latex or light garden gloves.) Optional: masking tape to wrap ends of fingers.
- Three to five slightly different textures of sandpaper cut into squares so that each participant has a square of each of the sandpapers.
- Playing cards--one deck per four to five participants. Optional: puzzles; one puzzle per four to five participants.

FOR IMPAIRED TASTE:

- Dixie cups, pitchers, napkins
- Mix a package of cherry unsweetened Kool-Aid® with water. DO NOT ADD SUGAR!
- Make tasteless cookies. (You may want to cut the recipe in half.) Sift 2 cups flour and ½ teaspoon baking powder. Blend in ½ cup shortening. Add 2 eggs. Refrigerate 1 hour. Roll into small balls and press flat with a fork, dipped in flour. Bake at 400°, 6-8 minutes. Makes 60 cookies about 1 inch in diameter.

FOR IMPAIRED SMELL:

- Apple, potato, carrot, turnip, and/or onion - cut in small cubes
- Toothpicks
- Optional: containers of fragrances, food extracts, and spices

HAVE FUN PREPARING AND CONDUCTING THE LESSON!

INTRODUCTION TO LESSON

Discuss the purpose of the lesson, which is to focus on the common sensory changes--hearing, vision, touch, taste, and smell--that occur in the later years of life. Not only will these changes be discussed, but group members will be given handicapping conditions that approximate these changes and will be required to complete common day-to-day tasks. This experience is intended to give participants a greater understanding of older family members and friends who have experienced changes in the sensory systems.

It is important to understand these changes because they are experienced by many older adults. And it is through our senses that we keep in touch with the world around us. Such changes can affect an individual in several ways:

- Communication and interaction with others
- Increased dependence on others
- Mobility
- Perception of and response to the environment
- Feelings about oneself

EMPHASIZE THAT SENSORY CHANGES OCCUR TO DIFFERENT DEGREES IN DIFFERENT PEOPLE AND THE RATE OF DECLINE DIFFERS MARKEDLY AMONG OLDER ADULTS. (GROUP MEMBERS WILL EXPERIENCE ONLY ONE DEGREE OF CHANGE.) MANY OLDER PEOPLE DO NOT EXPERIENCE THE CHANGES TO THE DEGREE THAT GROUP MEMBERS WILL EXPERIENCE THEM. However, it is important to understand that changes may have a significant impact on an older person. Stress also that some older people experience these changes to a much greater degree. Some also have two or more changes whereas in most instances group members will only experience one change at a time.

It is more important to understand these changes if group members have contact with nursing home residents because many residents have two or more changes. Multiple sensory handicaps are the rule rather than the exception.

Many sensory changes have their beginnings during the forties and fifties, however, usually they do not have a significant impact on an individual until after the sixties. Changes increase in severity each decade after age 65. For example, by the late seventies or early eighties, sensory deterioration can be quite serious for some older adults.

Before beginning discussion and simulation of specific changes, you may want to begin by presenting questions such as the following:

"What is it like to hear only a mumbling voice when someone speaks to you? How does it feel to have poor vision and no longer be able to read a newspaper or book--particularly if reading always has been a favorite activity? Why do some older people complain that food just doesn't taste as good as it did when they were younger? We will find answers to such questions as you step into the shoes of an older person during the next hour."

VISION CHANGES

Introductory Information

- Changes in vision and hearing are the most widespread of the sensory changes in the later years. They also tend to have a greater impact on individuals than other sensory changes.

- The majority of older adults (over age 65) have good to adequate vision, but several aspects of vision do change with age. These changes include decreased visual acuity (sharpness), farsightedness, changes in color perception, decreased sensitivity to light, and decreased ability to adapt to glare.

- One of the most common changes, usually beginning in the forties, is loss in the ability to see as clearly as when the person was younger, especially fine details, for example, very small print and the eye of a needle. The Center for Health Statistics reports that by the age of 65, one-half of all people have visual acuity of 20/70 or less; 20 percent cannot obtain corrected vision that allows continuation of normal activities. In a National Optometric Association survey, one-third of people age 65 and older reported an inability to see well prevented them from doing things they wanted to do. In a nursing home as many as 25 percent of the residents may be legally blind and another 35 percent have low vision.

Simulation

Have group members put on the cellophane eye covers and tell them to keep the eye covers on until they are told to remove them. Take the participants through several (3-4) activities. Suggested activities include the following:

- Tell participants they are going out to lunch (dinner) with you. When they go to their closets to get their favorite blouse (shirt) to wear, they find a button is missing. Their first task is to thread the needle and sew a button on their blouse. (Supplies for each participant: 4"x4" fabric square, small holed needle, thread, and button.)

- Tell participants there has been an accident and they have been asked to immediately call a specific person. Give them the name of someone they are to find in the telephone book. (Supplies: telephone books or 3-4 pages photocopied from telephone books. Give each participant a telephone book or have them share.)

- Pair participants. Tell them you have a fun activity, a crossword puzzle, and that it was developed for sixth graders and can be completed by most adults in 7-10 minutes. Since they are working in pairs, tell them you will give them a maximum of 7 minutes to complete the puzzle, since that should be adequate time. (Supplies: photocopies of the attached crossword puzzle.)

- If you have several empty prescription bottles, have participants try to find a particular prescription.

- Pair participants. Have one person read an article in the newspaper or magazine to their partner. Then have the participants change roles. (Supplies: newspapers and/or magazines.)

You can develop your own exercises by thinking about day-to-day activities. A good task to end the vision simulation is presented as follows:

"You qualify for certain benefits (for example, Social Security, Food Stamps, or Weatherization program) and must complete the necessary forms. So far, you have been very fortunate because you have experienced only one impairment, but now you will be given additional impairments because there are older people who have multiple disabilities. You have had a stroke and have difficulty writing, so as you complete the form, you must write with the hand opposite your writing hand. At the same time you are writing, you also must move the leg opposite this hand in a counter-clockwise circle." (Supplies: photocopies of attached form, one copy for each participant; pencils.)

NOTE: This movement of the leg is not associated with a stroke. Some participants, however, may ask if this does occur with a stroke. You may want to ask participants what happened as they were completing the form and writing with their opposite hand and circling their leg. They will usually report they had difficulty concentrating.

The purpose of the circling is to force people to concentrate on two tasks--completing the form and circling the leg. This makes it difficult for them to do as well with their writing. Relating this to older people, we find that some who have had strokes will know what they want to do--for example, write a letter--but they are not able to do so easily because of the interference in the message between the brain and the hand. This can be frustrating.

Additional suggestions for you, the leader-teacher:

- Have the cellophane eye covers folded so that group members' vision will be impaired to different degrees. Some people will experience frustration because they are not able to accomplish tasks as rapidly as the person seated next to them (of course their vision may be impaired to a greater extent); some may become impatient because they have to wait for the person next to them to complete a task before moving on to the next task; and some may become upset when working in pairs if their partner complains of not being able to see the writing. Discuss these differences and the feelings and responses of participants.

- Limit the amount of time for each activity. Several participants will experience frustration because of the time limits, but this is similar to the frustration people (of all ages) with limited vision experience when sighted people rush them.

- You may choose to "help" a couple of participants, without asking if they want or need the help--for example, state, "Let me help you," and then complete the tasks. This, too, very commonly happens in the real world. After the simulations, talk about how these people felt about your help. Some may be thankful, others resentful. This will serve as a good basis for discussing personality as a factor in a person's response to a disability and assistance from others, the importance of asking the handicapped if they want assistance, and the need to adjust one's pace to that of the handicapped person.

Post Simulation Discussion

Ask the group, "What were some of your feelings?" Discuss their emotions and the basis for them. Feelings commonly expressed include frustration, stupidity, awkwardness, insecurity, unsure about self, and loss of independence. Ask participants how their activities might be affected if their vision were impaired. Examples such as the following may be shared:

- Enjoyable pastimes such as reading and watching television might be reduced or eliminated.
- Inability to continue valued correspondence with loved ones, inability to write checks or pay bills.
- Interference with driving a car, using a bus, marketing, and getting around town; may have to become more dependent on others for assistance.
- May appear visually disarrayed to others; colors in clothing may not be well coordinated and person may not see stains.
- May feel unsure of self and vulnerable in new surroundings. Some older people with limited sight, for example, refuse to step outside the walls of a "safe" apartment or home.

Share with group members other changes in vision older people experience.

- Color perception. The lens of the eye yellows with age (using yellow cellophane simulates to some degree this change) and filters out colors at the blue end of the light spectrum. As a result, the older person may not be able to discriminate between shades of blues, greens, and violets. Colors more easily distinguished by the aged eye are the warm colors--yellows, reds, and oranges.
- Decreased sensitivity to light. Pupil size becomes smaller with age and less light enters the eye. As a result, the older person needs more light to see as effectively as a younger individual.

  The eye also decreases in its ability to adapt to changes in light level. Thus, an older person requires more time to adjust to abrupt changes in light levels than a younger person. Older people will experience momentary blindness at night from lights of oncoming cars.
- Increased sensitivity to glare. Glare that is hardly noticeable to a younger person often creates difficulties for an older adult.

Ask participants, "What are some implications of these changes for you as you relate to older people and grow older yourself?" "What can you do to help the vision-impaired older person?" Be prepared to discuss some of the implications as discussed on pages 2 and 3 of the bulletin, Growing Older: Sensory Changes.

HEARING CHANGES

Introductory Information

- Hearing loss affects more older people than any other chronic condition. It is estimated that less than 12 percent of adults over the age of 65 have normal hearing loss.

- Between 30 to 50 percent of older people have a hearing loss that significantly affects their communication and relationships with others. In the nursing home population, approximately 70 percent have a significant hearing loss. In general, more older men experience greater losses in hearing than older women. This is probably due to the noisier environments in which men have worked. As the leader-teacher, you may want to share with participants a "humorous thought" shared by an 80-year-old man at a workshop. He stated, "There is a purpose to hearing loss among older men. It is God's plan--yes, God's plan--to allow old men to live with old women."

- Hearing is crucial to mental health in later life. Hearing loss tends to result in greater social isolation than does blindness. People also tend to be less understanding and patient with a person who has a hearing loss than with a person who has a vision handicap.

- There are two major hearing losses experienced by older adults. One is loss in the ability to hear volume. (You may want to demonstrate this by reducing the volume of your voice.) However, volume loss is usually compounded by the most common loss associated with age - PRESBYCUSIS (prez bə´ kyüsəs).

- Presbycusis is loss in the ability to hear high frequency sounds. The vowel sounds, "a", "e", "i", "o", "u" are usually heard quite well. They are low-pitched. The problem is with the consonants (example: ch, sh, s, z, f, p) which are located in the high frequency range and are frequently inaudible. Research indicates that all of us, if we lived long enough, probably would suffer some degree of hearing loss because of presbycusis. The person with presbycusis hears speech, but it usually sounds garbled and muffled. Words are easily confused. As a result, the person with presbycusis may give inappropriate responses during a conversation.

Simulation

- Have participants make three columns on a sheet of paper, labeling the columns "A", "B", and "C"; then have participants number from 1 to 10 down the left hand side.

- Tell participants, "I am going to play a cassette tape recording, The Unfair Hearing Test. It will simulate for you what it is like to have presbycusis (column A), volume loss (column B), and to wear a hearing aid (column C). Ten words will be stated for each simulation. Write down on your paper the words that you hear."

- Stop the tape immediately after "juice" is stated for column C.

- Participants will usually want one or two minutes to compare their responses before continuing the discussion.

- Ask the group, "How would you feel, or what might be some of your behavior, if your hearing was like that of the presbycusis demonstrated in column A?" Discuss their responses. Keep in mind some of the information presented in "Reactions to Hearing Loss" on page 4 of Growing Older: Sensory Changes.

- Tell participants the words that were stated in The Unfair Hearing Test (the same words were repeated in each column):

1. Fill	6. Wedge
2. Catch	7. Fish
3. Thumb	8. Shows
4. Heap	9. Bed
5. Wise	10. Juice

Before reading one of the words (#4 Heap is a good one) ask participants the word they wrote down in column A. Point out to them that the vowel sound was generally heard, but the difficulty was with the consonants, "h" and "p".

Post Simulation Discussion

Discuss the implications of hearing loss for family members and others who relate to the hard-of-hearing older adult. Ask the participants, "What can you do to improve communication with a hard-of-hearing older person?" Draw out as many suggestions as possible from the group. Familiarity with the points outlined under "What You Can Do To Help," pages 4 and 5 of Growing Older: Sensory Changes, will allow you to offer additional suggestions. The following information also may be helpful to you during the discussion:

- Many hard-of-hearing rely partially on lip-reading to get a message, however, it is not easy to lip-read words. Also, many speakers are sloppy in their speech and do not form words distinctly with their lips which makes it difficult for the person who relies on lip-reading. The following activities can illustrate this point: Mouth the phrase, "Do you suffer much?" Then ask participants to state what you said. Another word to mouth is "failure."

- There are a number of devices to help the hearing impaired. These include:

  * Hearing Aids (refer to page 4 of Growing Older: Sensory Changes).

  * Flashing lights to replace fire alarm sound systems.

  * Inexpensive television attachments that increase the sound without disturbing other listeners.

  * Television adapter for "closed caption" programs. Information about closed caption television is available by writing to: National Captioning Institute, P.O. Box 57064, West End Station, Washington, D.C. 20037.

  * Telephone companies have devices available that can be attached to telephones to amplify voices.

- Sometimes people will say, "Grandma (Grandpa) says she's/he's hard-of-hearing, but just when you don't want her/him to hear something you've said, she/he seems to hear it." The differences may be due to differences in the environment, e.g. acoustics in the room, background noise, and pitch of voice (low vs. high).

- Hearing is hard work. It takes a tremendous amount of energy straining to hear and concentrating on listening. By the end of a day--or even an hour--if you are hard-of-hearing, you can become exhausted. The hard-of-hearing person may hear less well when fatigued or ill.

- Hearing loss reduces one's perception of the environment and may lead to suspicious and paranoid behavior. If you were hard-of-hearing and heard only part of what was being said, including your name, you might wonder, "Are they talking about me?" You might feel others are laughing at you when everyone but you is laughing. You didn't hear the joke that was told.

- It is sometimes difficult and annoying to converse with the hearing impaired. Yet, it is important to try to counteract to some degree the isolation of deafness. DULL EARS DON'T MEAN A DULL MIND.

TOUCH

Introductory Information

- Although research is limited, studies suggest an age-related decline in the ability to detect things by touch and a decreased sensitivity to pain.

- The sense of touch makes it possible for us to identify pressures on our body, for example, when shoes pinch our toes. With a decreased ability to sense things through touch, it can become more difficult to manipulate objects and distinguish textures on the basis of touch alone. A person may tend to drop things or grip objects, such as your hand, very tightly. People who have lost sensitivity of the touch receptors on their feet may fall before they know their feet are on solid ground. A person also may have a delayed reaction when touched or may not even know he/she is being touched.

- Decreased tactile sensations also can be caused by:

  * Diseases such as Parkinson's Disease and Multiple Sclerosis.

  * Small cardiovascular accidents which go unnoticed and cause sensory deficits.

  * Hands swollen because of reduced blood flow.

  * Arthritis, which causes reduced movement of hands and fingers.

- As a result of decreased sensitivity to pain, an older adult is more likely to be burned or cut and not know it until severe damage has occurred. Refer to the section on "Touch," page 6, Growing Older: Sensory Changes.

Simulation

Have participants put on the latex or surgical gloves. If you were unable to obtain these, have participants wrap the ends of their fingers with masking tape. Possible activities could include the following:

- Obtain three to five slightly different textures of sandpaper. Cut into squares so that each participant has a square of each of the sandpapers. Have participants close their eyes and try to arrange by touch the sandpapers from the finest to the coarsest.

- Have participants form groups of four or five to play a card game, "War". If desired, have participants also put the cellophane over their eyes to simulate a multiple impairment. Have the following directions typed for the card game and give to one person in each group to read aloud.

    * Shuffle the cards.

    * Deal the cards so they are evenly distributed among the players.

    * Cards are kept face down. Each player turns one card face up.

    * The highest card wins all the cards.

    * If two or more players turn up the same card, Bridge rules are followed, i.e. spades high, hearts, diamonds, and clubs low.

    * The player with the most cards at the end of the game is the winner.

- In groups of four to five have participants put together a puzzle.

- See activity suggestion under "Taste" before concluding the touch simulation.

Post Simulation Discussion

Discuss the implications of decreased touch and pain sensitivity and precautions that can be taken. The following information may be helpful during the discussion as well as the information presented in the bulletin.

- Lowering the temperature of a hot water heater can help reduce the possibility of accidents and severe burns due to decreased touch and pain sensitivity. Up to 125° there is usually time for a victim to make known his/her distress and/or get out of the water. But at 130° the time gets more critical--at this temperature water is hot enough to cook with and it can cause third degree burns, the worst kind, in 30 seconds. At 135° this decreases to eight seconds and at 145° it's only two seconds.

- Because of decreased sensitivity to pain, an older person is less likely to perceive internal body pain or a rising temperature as easily as a younger person. A result is that an illness may progress to an advanced stage before it is detected. It is also possible for a person to be aware of a discomfort, but be unable to isolate its source. Something as localized as an ingrown toenail, infected tooth, or impacted bowel may not be recognized as such. The frustration of feeling miserable and not knowing the cause can lead to irritability.

TASTE

Begin this segment of the lesson by saying something like, "You've been a super group. After all you've been through, I have prepared a special treat." Then either serve the participants the tasteless cookies and bitter punch or preferably, while the participants still have on the "handicapping" materials for the "touch" simulation, have certain people get the cookies and pour the punch for others and have participants eat while handicapped. As participants eat and drink, they will usually say the cookies and punch are "bitter," "awful," "tasteless," or "who taught you to cook?" This serves as an introduction to discussing changes in taste sensitivity. The following information as well as that presented in the bulletin may be helpful to share:

- Research indicates that the senses of taste and smell decline with age. Older people cannot identify odors and food flavors as well as younger persons.

- The average person has lost 50 percent of his/her taste buds by age 65. However, changes in the ability to taste flavors generally are not likely to occur before the late 70's. By the late 70's, the average person has 1/6 of the taste buds as a 20-year-old.

- One of the most common complaints of residents in nursing homes is the food--"it doesn't taste good," or "it tastes bitter." Although it is impossible to cook meals in an institutional setting like in one's home, the decreased sensitivity of a person's taste buds may account in part for the dissatisfaction obtained from food, and not solely the cooking; the average age of nursing home residents is in the early 80's.

- Some 8,000 taste buds on the tongue make a person aware of flavor. The taste buds that tell you something is sweet are located on the tip of the tongue; those that detect salt are on the sides. Further back on the sides are the sour detectors. The buds that pick up the bitter tastes are located in the back. Studies indicate that the taste receptors that identify sweet and salty flavors are the first to decline, while those that sense bitter and sour flavors tend to function well into old age.

- Other factors that contribute to greater problems in taste sensation and satisfaction include a lifetime of smoking, poor mouth and dental hygiene, decline in salivation, receding gum linings, ill-fitting dentures, loss of teeth, and nasal congestion.

Discuss the implications of these changes for older adults and for persons who prepare meals for older family members. Such implications are discussed under "Taste" in the bulletin.

SMELL

Introductory Information

- The sense of smell declines with age, but the exact mechanism of this change is not known; however, it is probably due to atrophy of the nerves.
- Two-thirds of our taste sensations depend on the ability to smell. Therefore, a decline in this sensory system may further depress on older persons appetite or interest in food.
- Up to 40 percent of persons over the age of 80 have difficulty identifying common substances by smell.

Simulation

- Before the meeting, cut into small cubes an apple, potato, carrot, turnip, and/or onion.
- Have participants form into groups of two. Have one person close their eyes and simulate loss of smell by holding his/her nostrils closed with his/her thumb and index finger, using nose plugs, or tearing a sheet of tissue paper in half and gently pushing one piece into each nostril.
- Using toothpicks, the partner places the vegetables/fruits, one at a time, under the "handicapped" persons nose for smelling and then feeds it to him/her without telling the person what he/she is eating. The "handicapped" person is asked to respond quickly in naming the food.
- Have partners reverse roles.
- An optional activity is to place various containers of fragrances, food extracts, and spices under the noses of "handicapped" individuals and have them try to identify the substances. This can be done with having everyone "handicapped" at the same time and the leader quickly moving bottles, one at a time, under participants' nostrils. The participants' eyes should be closed.

Post Simulation Discussion

- Discuss the implications of loss of smell for gaining satisfaction from food and identifying common odors.

- Emphasize that for the person who has experienced losses in both sight and smell that the enjoyment from food is further decreased. For the person who has experienced loss in the ability to smell and taste, the attractiveness of food is important in enhancing appetite, but what about the person who also cannot see the food very well? Explaining to the person the food that has been prepared will allow him/her to think about the aroma of the food.

Conclusion

- Emphasize the uniqueness of each older person. Not all older adults have experienced the changes to the degree that the group members just experienced them, but it is very important that we understand the effect a significant change can have on an older adult.

- Sensory changes generally occur over many years, not suddenly as in the simulations. Most older adults adjust very well and learn to compensate. Personality, however, is a major influencing factor in an individual's adjustment.

- Ask participants to think about one older person they know who has experienced a sensory change and ask themselves, "What can I do to improve communication with that person?" "What changes could be made in the environment to enhance the individual's independence, safety, and quality of life?"

- Hand out copies of Growing Older: Sensory Changes.

REMINDER

- Return the cassette tape, "The Unfair Hearing Test" to the county home economics Extension agent.

Vicki L. Schmall, Gerontology Specialist, Oregon State University Extension Service

OREGON STATE UNIVERSITY EXTENSION SERVICE

Extension Service, Oregon State University, Henry A. Wadsworth, director. Produced and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914. Extension work is a cooperative program of Oregon State University, the U. S. Department of Agriculture, and Oregon counties. Extension invites participation in its programs and offers them equally to all people.

OREGON STATE UNIVERSITY
EXTENSION SERVICE

SP 54-077
May 1985

SIMULATION: A METHOD TO UNDERSTAND PHYSICAL CHANGES ASSOCIATED WITH AGING

Vicki L. Schmall
Extension Gerontology Specialist

A method to help people understand the physical changes associated with aging is simulated activities. Individuals are given handicapping conditions that approximate reality and are required to complete common day-to-day tasks.

METHODS/MATERIALS

SIGHT: With increasing age, the eyes decrease in their ability to see clearly, particularly small details such as the eye of a needle or directions on medications. The average 65-year-old has a visual acuity of 20/70 or less. Several studies suggest that the lens of the eye yellows with age and filters out colors at the blue end of the light spectrum. Warm colors (yellow, orange, and red) are more easily distinguished by many older people than cool colors (blue, green, and violet).

To partially impair vision, fold cellophane or plastic wrap several times. Yellow cellophane is recommended. Cheesecloth, cling gauze, sunglasses or laboratory protective glasses smeared with petroleum jelly also are effective.

Loss of peripheral vision, as caused by glaucoma, can be simulated by covering the temple area and lenses of glass frames with black construction paper or nontransparent contact paper, leaving a 1/4-inch diameter hole in the center of each lens. Loss of central vision, as occurs in macular degeneration, can be simulated by covering the inner half of the lenses of glasses with construction or contact paper. Use night shades to simulate total blindness.

HEARING: Two major hearing losses that occur with age are decibel loss--reduced ability to hear sounds of low intensity--and presbycusis--loss in the ability to hear high frequency sounds. Industrial earplugs are most effective for simulating volume loss.

Alternative methods are to use cotton balls or swimmer earplugs or to play an audiotape, television or radio at a low sound level. A more pronounced effect can be obtained by wearing earmuffs or stereo headphones.

Media that simulate hearing and/or vision changes common in the later years include a cassette audio-tape "Getting Through" (ask for: "Changing Listening Situations for Older People." This includes the aduio-tape and instructional booklet; Institute of Gerontology, University of Michigan, 520 E. Liberty St., Ann Arbor, MI 48109) and slide tape "Age Related Vision and Hearing Changes"

Educational programs for farm, forest, family, community, energy, youth & marine audiences

(Institute of Gerontology, University of Michigan) and "Sensory Deprivation Simulation" (Gerontology Program, University of Nebraska, Box 688, Annex 24, Omaha, Nebraska 68101).

TASTE: Food that smells and tastes good is important to good nutrition. Many older people however, experience a decline in their senses of taste and smell. A common complaint of the very old is that "the food just doesn't taste good anymore" or "this food tastes sour or bitter."

Foods that are bland or saltless--for example, saltless crackers and colored water, unsweetened drink mix, or weak lemonade--can simulate loss of taste sensitivity. A recipe for "tasteless cookies" follows: Sift together 2 cups flour and 1/2 teaspoon baking powder. Blend in 1/2 cup shortening. Add 2 eggs. Refrigerate 1 hour. Roll into small balls and press flat with the tines of a fork. Bake at 400°, 6-8 minutes. Makes 60 cookies about 1 inch in diameter.

SMELL: To simulate loss in the ability to smell, use nose plugs, place cotton in the nose, or hold the nostrils closed. Blindfold individuals and present them with a variety of odors to identify.

TOUCH: Skin sensitivity and the ability to detect pain decreases with age. It is more difficult for the older person to distinguish textures by touch alone. Because pain threshold increases, an older person is more apt to be cut or burned and not know it until severe damage has occurred. For example, the hot temperature of both water or a heating pad may not be felt readily.

Loss of tactile sensitivity may be simulated by wearing latex or surgical gloves, wrapping tape around the tips of fingers, or applying rubber cement to the fingertips and letting it dry.

MOBILITY/DEXTERITY: Bone and muscular changes mean decreased ability to ambulate and slowness in movement for some older people. Illnesses such as arthritis, Parkinson's disease, and stroke may severely limit a person's dexterity or mobility.

To simulate loss of finger dexterity, wrap masking tape around each finger, particularly the thumb and index finger, or tape splints on several fingers. Knee and elbow joints may be immobilized by using splints or wrapping them with 3- to 4-inch elastic bandages. Have individuals also use a wheelchair, cane, crutches, or walker.

More than one impairment may be experienced simultaneously to simulate multiple handicaps. For example, a person may be made both vision and hearing impaired.

ACTIVITIES

Give the "impaired" several tasks. The visually impaired might be asked to find a number in the telephone directory, prepare a meal, read an article in the newspaper, or thread a needle. The blind might be asked to peel a cucumber or eat a meal.

An "arthritic" individual might be asked to open a child-proof container and perform such everyday tasks as tying shoelaces, peeling an orange, buttoning a shirt, or writing a letter.

It is particularly effective to utilize everyday activities that the non-handicapped often take for granted but which may be more difficult or take more time for the handicapped person to accomplish. By limiting the time to complete tasks, individuals will experience the frustration the handicapped sometimes feel when others unduly hasten them.

DISCUSSION

Discussion following the simulated activities should focus on reactions, feelings, and implications of such impairments for older adults and for individuals as they work and relate to older persons who have physical impairments. Instructors should emphasize that most older people are in relatively good health and for those older persons who experiece such physical changes, many compensate for them in various ways.

RESOURCES

Two publications of the Oregon State University Extension Service are helpful in conducting programs on sensory changes and aging:

- PNW 196, Growing Older: Sensory Changes (bulletin)
- HE 12-001L, Growing Older: Sensory Changes (Leader/Teacher Guide)

These may be ordered from the OSU Bulletin Mailing Office, Industrial Building, Oregon State University, Corvallis, OR 97331. The bulletins might also be available through your local county Extension offices in Oregon. There is a a charge for the PNW ~~(50¢)~~ 25¢ plus 25¢ for postage for single copies.

OREGON STATE UNIVERSITY EXTENSION SERVICE

Extension Service, Oregon State University, O. E. Smith, director. Produced and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914. Extension work is a cooperative program of Oregon State University, the U.S. Department of Agriculture, and Oregon counties. Extension invites participation in its programs and offers them equally to all people.

Application Form

Name _____ Age _____

Address _____

Phone Number _____

Social Security Number _____

Weight _____ Height _____ Eye Color _____

Spouse's Name _____

Children _____

Interests:

CROSSWORD 3

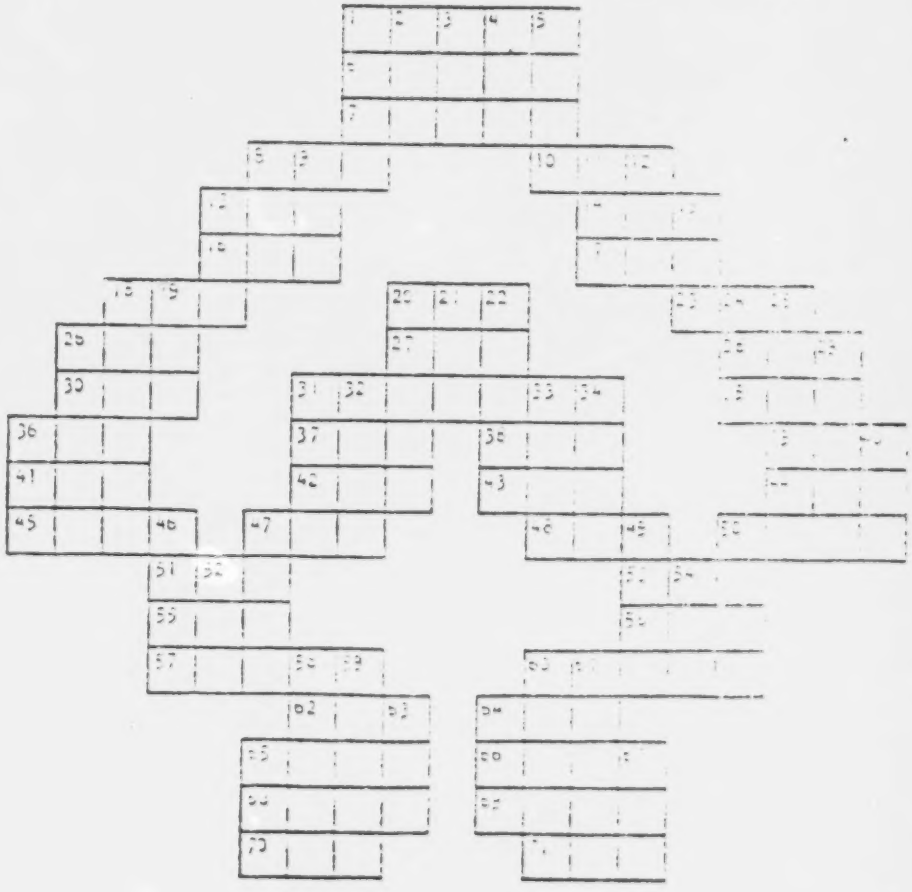
ACROSS

1 Postage item
6 Paramour
7 Angry
8 Between Fri. and Sun.
10 Thus far
13 Golfing average
14 Exist
16 Lodge member
17 —— for tat
18 Abyss
20 Manner of payment: abbr.
23 Automobile
26 Command a dog to attack
27 Spike of corn
28 House pet
30 If you fail, do this again and again
31 Conflict
35 Vane direction
36 Feather stole
37 Fixed routine
38 Perceive
39 Bottle top
41 Skill
42 Double curve
43 —— Antonio
44 "A rose —— rose . . .": 2 wds.
45 Of the age between twelve and twenty
47 Give back: abbr.
48 Pig's abode
50 Summer drinks
51 Run the gamut from —— Z: 2 wds.
53 Circle part
55 Energy
56 Bosh!
57 Leavening
60 Decreases
62 Refrain syllable
64 Soup utensil
65 Edible seed
66 In a frenzy
68 Give forth
69 Actor Andrews
70 Superlative ending
71 Take-home pay

DOWN

1 Long cut
2 High rocky hill
3 Miss Gardner
4 Encountered at the opera
5 Animal's victim
8 "My Gal"
9 Noah's floater
11 Dine
12 Three: prefix
13 Fondle a dog
15 And so forth: abbr.
18 Sea robber
19 Like wintry roads
20 Pennies
21 Edible grain
22 Lady's garment
24 Expert
25 Spoiled
26 Supermarket
29 Annoy
31 Algonquian Indian
32 Expel
33 Oceans
34 Indian dwelling
36 Flying mammal
40 Mas' mates
46 Sea force
47 Italian name for the Eternal City
49 Knitting worsted
50 Bible book
52 Ascot
54 John Doe and Richard ——
58 Flower stalks
59 Characteristic
60 Miss, Mrs. or Ms.
61 Make amends
63 Picnic spoiler
64 Beatnik's home
65 Spelling match
67 Krazy —— comic strip

Solution on page 61.



Housing the Elderly

By Christine F. Salmon
and F. Cuthbert Salmon

Aging is not an accident and we would not want to prevent it from happening even if we could. Nor is aging necessarily a problem. Aging is a process of change: today's aged are the children of yesterday and tomorrow's aged are the youth of today.

In the United States there are over 22 million persons age 65 or older, and this figure will double in the next 40 years. But in spite of these increasing numbers, older people need to be considered as individuals rather than as a category.

Housing for the aging is a matter of providing the best possible environment for individuals in their later years. This housing must provide a physical and social environment that extends the time during which the elderly can live independently. The environment must provide safety and convenience without conveying an association with the ill or infirm, and should help to stimulate interest in and zest for life.

Architects and designers must, therefore, consider the people who will occupy the spaces they create. The comfort and well-being of older individuals are particularly dependent on the functional and aesthetic qualities of the space they occupy. This is due partially to the effect aging has on the senses.

Sight

Decline in the sense of sight frequently occurs with advancing years. Failing sight is also often accompanied by deterioration of psychomotor functioning and the inability to adapt from light to dark and dark to light.

The aging, therefore, require virtually double the normal amount of light to augment their failing vision.

Sound

Perception of sound decreases as age increases. For the aging, then, alarms and signals need to be not only louder but also lower in pitch.

Housing for the aging should be well insulated to prevent the transmission of sound. This is a requirement for older people when they are ill or napping and also for neighbors, since older people frequently talk loudly or need more volume from radio and television.

However, adequate insulation should not be interpreted to mean freedom from noise. Distant and impersonal sounds can be reassuring for the elderly. Such sounds are also stimulating and help to establish a sense of identification and orientation.

Smell

The sense of smell may also decline with advancing age and make it difficult for the elderly to detect hazards such as gas fumes or smoke. Furnace, chimney, and flues should be inspected and cleaned regularly by qualified experts. Automatic fire alarm systems and automatic shut-offs should be provided on all gas equipment. Throughout the dwelling, odors should be pleasant; mustiness is depressing.

Touch

The sense of touch becomes less acute for the aging, yet they are more subject to injury from burns. Exposed steam or hot water heating systems need to be protected. Setting the domestic hot water at 110°F (43°C) is also advisable.

Changes in textures of materials are useful for denoting elevation changes and turns or changes in corridors. In this way, the sense of touch can aid a failing vision that may need help to comprehend the environment.

Mobility

Limited mobility of the aging may vary from slight loss of agility to complete dependence on a wheelchair.

In dwellings designed for use by people in wheelchairs, paths of circulation should be simple and direct, with ample space to turn a wheelchair 180 degrees. Doors should be at least 3 feet wide. Floor surfaces should be smooth and scatter rugs completely eliminated. Highly glossed floors can be psychologically dangerous to the elderly even though the floor may not be slippery. Carpeting makes it hard to maneuver wheelchairs, yet it also cushions falls and provides soundproofing.

Both authors are architects for their own firm in Stillwater, Okla., which specializes in architectural needs of the handicapped. They are also both Fellows of the American Institute of Architects.

Christine Salmon is professor of housing, design, and consumer resources in Oklahoma State University's Division of Home Economics. F. Cuthbert Salmon is professor of architecture there.

Reprinted with permission from Journal of Home Economics.

The Bathroom

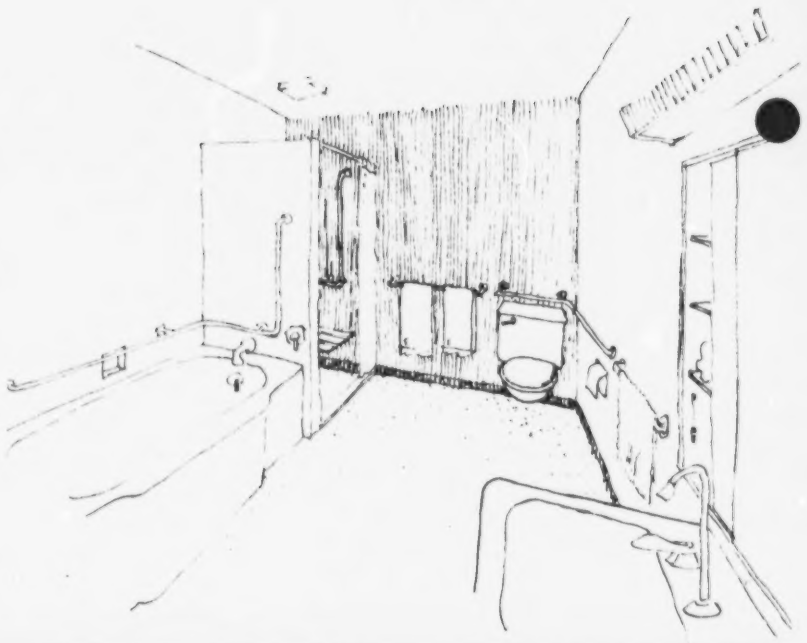
Sturdy grab bars 1 inch in diameter securely fastened at tub, shower, and toilet are convenient for all elderly persons and are essential safety devices for the more severely disabled.

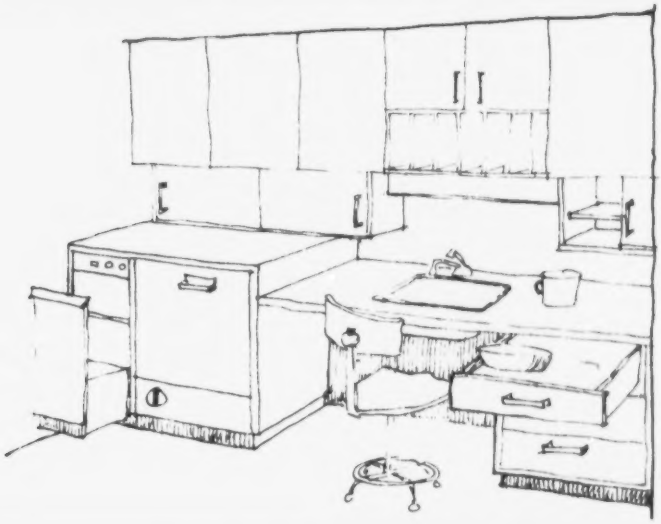
The toilet should be installed 20 inches from the floor – rather than the conventional 16 inches – for convenient use by persons in wheelchairs. A wall-mounted toilet provides easiest maintenance.

A bench or seat in the shower can be quite helpful to the elderly. A minimum 36-inch square shower with a low curb is probably ideal. Whenever possible, both a shower and a nonslip bathtub should be available. Controls for both tub and shower accessible from the outside that use valves with thermostatic controls are highly desirable.

A sink 36 inches from the floor is more convenient for elderly people and more usable by persons in wheelchairs than the conventional 31-inch-high sink. Faucet handles should be the lever-type rather than knobs. A mirror over the sink is desirable, but medicine cabinets with swinging doors are not.

A wall-to-wall chemical fiber carpet provides safe and comfortable floor surface. Ample lighting should be provided from all fixtures.



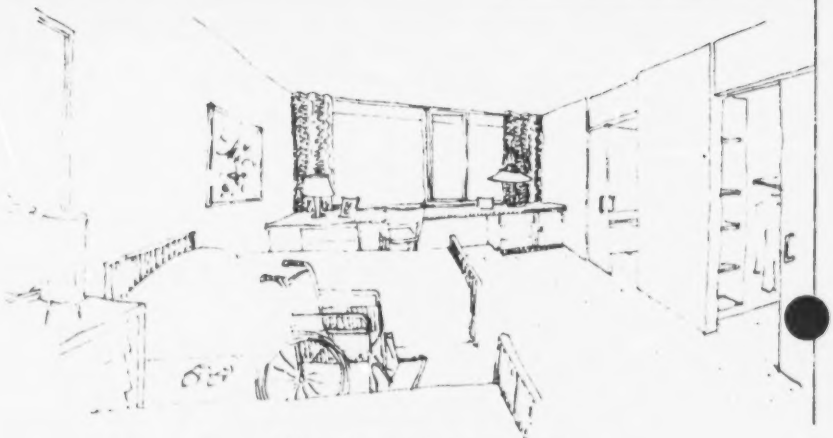


The Bedroom

The arrangement of furniture within the room should permit maximum mobility. Seating should be available not only for the elderly but also for visitors. Minimum clearance on both sides of beds should be 18 inches, with 36 inches between beds to facilitate bed making and nursing. If the room occupant uses a wheelchair, it is necessary to allow for at least 48 inches on one side of the bed.

Direct access to the bathroom is desirable and night lights should illuminate both bedroom and bath.

Sunlight in the room during winter and shade in summer is usually a comfort requirement. A pleasant view from the bed and windows with draperies rather than venetian blinds may offer psychological satisfactions.



159

Ramps, elevators, and stairs can be useful. Stairs should have adequate railings and ramps should have a pitch of 1 foot for each 12 feet.

To avoid accidents, doors should not swing into corridors or passageways. Passageways should be free of columns, radiators, pipes, and other projections.

Designers must also consider limitations of reach when designing interiors for the elderly. Electrical outlets placed high above baseboards and light fixtures that permit easy replacement of light bulbs are important. Kitchen counters 32 to 34 inches high are desirable, with openings underneath to accommodate a seated person in a wheelchair. Height of shelves and depth of work areas are also important considerations.

Climate

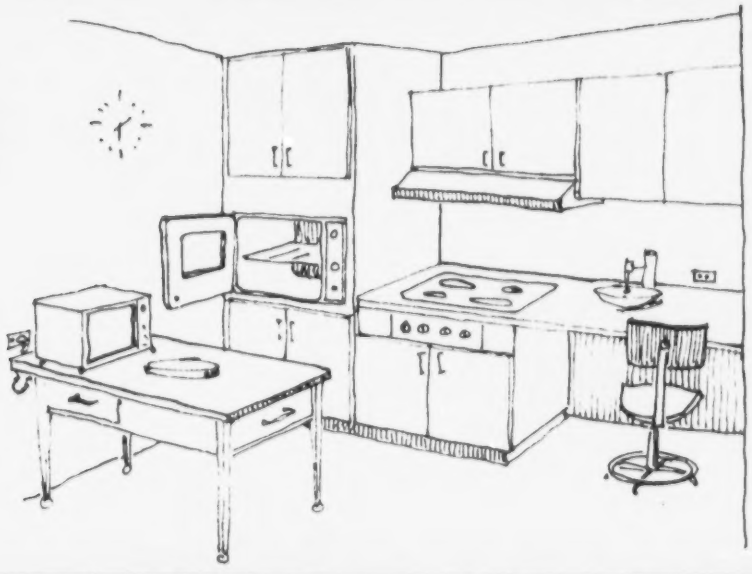
The elderly person is usually very conscious of drafts and inadequate heat. A temperature of 80°F (27°C) is desirable for body comfort in winter. Proper ventilation is important in warm climates, since the elderly are subject to heat prostration and body dehydration if ventilation is inadequate.

Heating systems for the elderly should be responsive and individually controlled. Heat needs to be uniform, of low intensity over a large area, and devoid of "cold spots." Properly designed windows can help avoid drafts; draperies and blinds can help provide light and sun control.

In dwellings for the elderly colors must be cheerful, yet restful, and the total environment should promote a feeling of comfort and well-being. Illness and mental deterioration are often influenced by environment and can sometimes be remedied by changing and controlling the environment.

It is said that the problems of aging are not problems at all – they are only a pessimistic way of looking at a great triumph of civilization.

It is time we stopped building pessimistic houses!

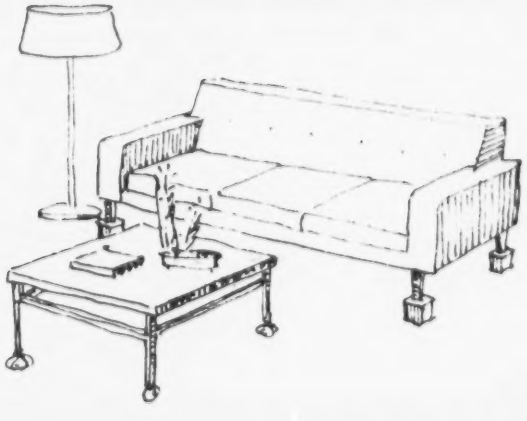


The Kitchen

The wall oven door is 29½ inches from the floor and the built-in range counter height is 32 inches. Both of these features permit convenient and safe use from a seated position. Controls placed at the front of the range counter and staggered heating units help reduce hazards when reaching rear burners.

The 29½-inch-high table with wheels may be stored under the counter, used as an extra work surface, or used to transport items. A posture chair or wheelchair may be conveniently used at the counter recess.

A shallow sink set in a 32-inch-high counter permits use from a wheelchair. Drawers are within easy reach from a seated position. A drawer with pull-out board provides additional convenient work surface. Racks above the sink for shallow pans, low wall cabinets, and the front loading dishwasher may all be reached from a seated position.



The Living Room

Standard furniture may be modified for use by people with limited mobility. A 16-inch-high sofa may be raised by wooden blocks to provide a 20-inch-high seat. This allows for easier transition to and from a wheelchair and is more easily used by many older people.

The coffee table with wheels or casters may be easily moved for convenient access to other furniture and for cleaning.

We all want to be listened to

- Consider the importance of careful listening.
- Study several principles of good listening, and suggest others you've found useful.
- Practice some skills of careful listening.

We all want to be listened to. And we've all felt the frustration of not being heard or understood. This activity looks at some characteristics of careful listening that can make discussions more productive and friendships stronger.

How to be a good listener

1. *Accept the other person.*

a. Suspend judgment. We all have a right to feel and believe as we do. Don't let your own values prevent you from hearing a different point of view.

b. If you're in the habit of contradicting what other people say, or if you often try to have the last word, catch yourself.

) *Pay attention, and show it.*

a. For the moment, set aside your own need to talk. Concentrate on what the other person is trying to say.

b. Keep appropriate eye contact. (In this society, members of the majority culture like a fairly direct gaze. They feel that a listener who looks away is not paying attention; but they don't like to be stared at. Members of some minority cultures are taught to keep very direct eye contact. And still others think it is rude to look people straight in the eye. These differences can lead to misunderstandings.)

c. Show that you're interested. Avoid distracting behavior, such as drumming your fingers, looking at your watch, or gazing out the window. Nodding your head, saying things like "Yes, I see what you mean," asking questions, and adding to the other person's ideas all show that you're involved.

But if you're not interested at all, it's probably better to let that be known tactfully than to pretend. Self-disclosure, letting your partner know you, is as important as accepting the other person.

d. Let the other person finish talking. Allow time to think and explain. Don't interrupt, and don't change the subject.

e. When you ask a question, listen to the answer.

3. *Try to understand what the speaker is saying.*

a. If you can't follow the words, say so. Ask the person to repeat. If your hearing is poor, let your partner know what will help.

b. Follow the person's thoughts. Don't take the lead, even when adding ideas.

c. Empathize. Imagine yourself in the other person's place. Tune in to the other person's feelings.

d. Notice what the speaker's body movements and tone of voice tell you. Are they consistent with the words?

e. You can check your understanding by paraphrasing or reflecting what the person has expressed. (For example, if the person hisses through clenched teeth, "I should cut that kid out of my will," you might respond,

"You'd like to punish her that much?") This kind of feedback helps both you and the speaker clarify communication.

f. If you don't understand, let the other person know. ("I don't think I'm following you," or "You seem anxious about that, but I don't quite see why," or "You mean . . . ?" or "Would you say that again?")

4. *Phrase questions thoughtfully.*

a. Be careful not to question too often. Conversation is not a quiz.

b. Except to seek simple information, avoid closed questions that lead to yes or no answers. Instead, encourage the other person to expand certain statements. ("And so . . . ?" or "How does that explain . . . ?") Open-ended questions generally ask *who, what, when, where, how,* or *why.*

5. *Summarize what you're observing.*

a. Keep track of what the person is saying. Listen for central themes.

b. Every so often, tie ideas together. Make connections. ("From what you've been saying, it sounds as if you're ready to . . ." or "Your feelings have changed from . . . to . . . ?")

6. *Refrain from probing, protecting, advising, and explaining.*

a. Resist the urge to defend or reassure the person. You can empathize and show sympathy and understanding. But defending and reassuring may keep the person from finishing — and may be off the mark as well.

b. Give advice only if asked for it.

c. Respect privacy. You can help the person clarify thoughts without probing.

7. *Respect confidences.*

8. *Other:*

_____

_____

_____

Talking with a deafened adult

Try to be no farther than three feet away so the hearing aid can do its job. Slightly exaggerate your lip movements to help lipreading. Use gestures and body language. Don't talk too fast. Use a normal tone of voice.

Practice

With one or two partners, practice careful listening. For subject matter, select one:

–Continuation of the *Getting acquainted* interviews in Cluster 1.

–*A formula for self-renewal* (following), asking you to rank and discuss 10 ways to bring new energy into your life.

–*How would you feel? What would you do?* (following), presenting situations for you to imagine yourself coping with.

I remember when —the importance of reminiscing

- Consider the benefits of reminiscence.
- Consider starting or joining a reminiscence group.

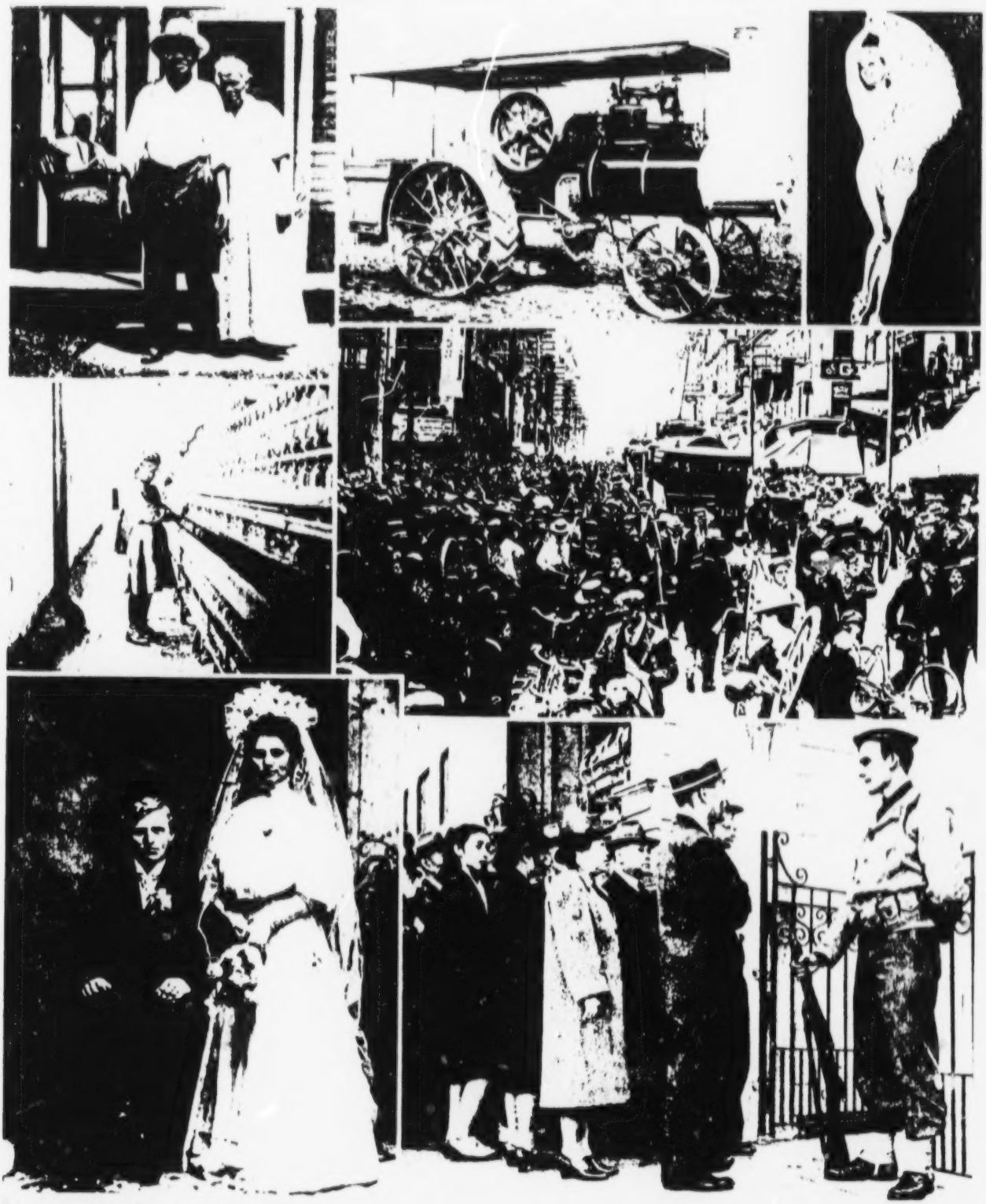
Life was tough during the Great Depression. In the '20s, things had been easy — business was brisk, the mood of the country was high. Or perhaps you remember it differently. Maybe the 1920s were not as romantic and roaring as nostalgia would have them, and the '30s not as terrible, either.

Do you remember the news of Pearl Harbor? Where were you when you heard FDR was dead? Did you listen to the speeches of Churchill? These are surefire conversation starters for anyone over 50. And the older you are, the more subjects you can talk about.

Thinking and talking about the past is called *reminiscing*. Reminiscing can be idle recall, a daydream kind of remembering, or it can be a purposeful search for a specific memory. It can range from occasional recollections and mild nostalgia to dwelling on the past. Reminiscing can be silent or spoken.

Reminiscence is one of the central activities of life. It helps us maintain our self-esteem. It helps us work through our grief. It increases our sense of purpose. Reminiscence is part of our lifelong development of personality. Talking about the past can preserve our identity in the present and future.

Some mental health professionals used to call "excessive reminiscence" a sign of deterioration. They reasoned that people who often "escaped into the past" must be very unhappy in the present. Those of us who spent too much time wandering down memory lane were, they said, in danger of losing our minds. And we sensed that our



See Appendix A for photo identification.

...steners put up with our stories mainly out of politeness. But now we know that reminiscing is necessary for emotional health — and oral history has become a national pastime.

Robert N. Butler* demonstrated the importance of reminiscing. In the early 1960s, Butler developed a procedure called the *life review*, in which a person brings together both pleasant and painful memories in appreciation of his or her life. Usually, rethinking past hurts brings new understanding. The person who does a life review generally gains in honesty, wisdom, and self-acceptance. Going over old ground with an interested and caring listener can tie up loose ends and resolve old regrets. It can put the failures, the disappointments, and the good times into a new perspective. It can clarify and refresh the meaning of one's existence on earth.

Maggie Kuhn says that if we look over our ...st, we will appreciate what we've lived ...rough: the ways we've coped and survived, the changes we've seen. Recalling past accomplishments and half-forgotten skills can motivate us and give us new confidence and energy.

Everyone, the world over, reminisces — including little children. Not all people review their lives in the same way or gain the same satisfaction from remembering, but everyone returns to the past in later years to complete unfinished business and to reach a degree of serenity.

1. Do you think reminiscence has value? For some ages more than others? What do *you* gain from reminiscing?

2. Do you agree that a deliberate life review can help a person gain serenity? What if the life has been full of anger, pain, and disappointment?

3. When you reminisce, what do you think about most — people? Pets? Possessions? Incidents? Good times? Bad times? How far into the past do you remember your dreams?

4. Which is keener: your memory for things you have seen, or your memory for things you have heard? How vivid are your memories of smells, tastes, and feelings? When you reminisce, how completely do you reconstruct the scenes? Do you reexperience your breathing, your heartbeat, your emotions, your body sensations?

5. Currently in your life, you are making memories. What will they be?

The Dreamer

He used to dream of things he'd do
When grown to be a man,
Beguiling boyhood years away
With many an idle plan.
And now, when grown to be a man,
He knows no greater joy
Than dreaming of the things he'd do
If he were still a boy.

Thomas Nunan

Action Plans

1. Take time to reminisce with another person. Use the skills of careful listening described in Cluster 2. You might start with some of the following topics. Or use the preceding photo montage to stimulate memories. For variety, think of captions for certain pictures and compare your interpretations with your partner's.

Self My earliest memory. One summer when I was (5, 10, 15, 20, etc.) My first ride in a car/train/airplane. The worst fright of my life. My education. My dreams. A spiritual awakening. The most important event of my life.

*Psychiatrist, gerontologist, first director of the National Institute on Aging. See *Recommended Readings* in the Moderator's Manual for a list of writings by Butler and others on reminiscence and life review.

Home and family Immigrating to this country. My grandparents. Losing a loved one. Our first electricity/indoor plumbing/car/radio/telephone/TV. Our idea of a good time. Pets. The birth of a baby. Our first home.

Work Childhood chores. My first job. Getting my working papers. Sweatshops. Union organizing. Starting a new business. Changing careers.

The world Childhood street games. What prices used to be. Art, music, dance. Vaudeville, silent film, talkies, early TV. The Great Depression. Travel. War. Communication.

For other ideas see Cluster 1, *Getting acquainted*, and Handout 3, *Self and world: assorted topics*.

2. With other interested members, form a reminiscence group to meet regularly. At your first meeting, set up ground rules of discussion. Reminiscence might start from topics on the preceding list or from captions you've created for the photographs. At some of your meetings you could read from memoirs and autobiographies, stories or poetry, or works such as the one-act play *Krapp's Last Tape*, by Samuel Beckett. It's the story of a very old man who replays the audiotapes he recorded of his ambitions when he was younger. The man ridicules the passions and dreams of his youth and middle years, which have come to nothing. Elizabeth Coatsworth's *Personal Geography* is a more uplifting comment on a long life. (See *Related Readings* for Cluster 4.)

3. Invite students from a nearby school to form a reminiscence group with you. Make sure everyone has a chance to talk. Record some of your meetings on audiocassette or videotape. Consider transcribing the recordings onto paper as historical records. Carefully edit the transcriptions, keeping the content of value, weeding out the hums and haws and irrelevant or overly repetitive parts. (See *Related Readings*.)

4. If you're not a resident of a nursing home yourself, join or start a reminiscence group there. Residents might like to have relatives join to hear family stories.

Whether you meet with your peers or with people of other generations, bring artifacts and mementos to illustrate some recollections. A dried flower, a menu, a report card, a letter, a valentine, a playbill, a newspaper, a sales receipt will make your descriptions more vivid and show how varied, yet similar, are the individual stories of life.

Each age of life is new to us; no matter how old we are, we still are troubled by inexperience.

Duc François de La Rochefoucauld

Remember discussion guidelines?
— Join the conversation. Speak up.
— Let others have a chance to talk.
— Listen.
— Respond to all group members.
— Stay on the subject.

Here's a basic list of questions you can use as a guideline for your personal history or for interviewing family members.

A Family History Questionnaire

By Virginia Allee

The purpose of this questionnaire is to provide you with a mind jogger, to help you in making notes on your own life or to guide you in recording the life experiences of another member of your family. The information you record will become an important link between you and your descendants. It will serve as a means of conveying a picture of what your life has been like, and a sense of what has been important to you.

At the top of a sheet of paper write: the full name, and the date and place of birth, of yourself, your mother (maiden name), your father, your brothers and sisters, your spouse, and your children; and the date and place of marriage for yourself, your brothers and sisters (with spouses' names), and your children (with spouses' names).

Write your thoughts on sheets of good quality paper, numbering each answer to correspond to the appropriate question. Write your name on each sheet, too, and leave room to add new thoughts later.

Read only a few questions ahead, or you will never get started. Combine questions if you wish, and skip those that do not seem to apply to you or that you cannot, or choose not, to answer. And answer any additional questions that occur to you.

Do not start out trying to produce a finished composition; just let your memories flow naturally. Later, you, or perhaps your child or great-grandchild, can edit it. Right now, you are simply gathering the all-important facts and memories.

Work for short periods of time. You can continue your answers at odd moments, or you can stop to ponder or discuss them. But spend your time writing, rather than rereading your earlier answers, or slow progress may discourage you.

Compose your answers as though you are writing a letter to your family—to people you know and love—for that is essentially what you are doing.

GRANDPARENTS

1. What were the names of your mother's parents?
2. When and where were they born? Where did they live?
3. What did he do for a living?
4. Do you have any personal memories of them? Describe.
5. What were the names of your father's parents?
6. When and where were they born? Where did they live?
7. What did he do for a living?
8. Do you have any personal memories of them? Describe.
9. Did you know your grandparents well?
10. What do you remember hearing about your great-grandparents?
11. Did you ever meet them?
12. Did your great-grandparents, grandparents, or parents come to the U.S. from a foreign country? What stories are told in your family about the crossing? Do you have any relatives in foreign countries?
13. What traditions are still practiced in your family?

CHILDHOOD

The family house

14. What type of house did you live in as a child? Describe.
15. What other buildings were on the same property?
16. Did you have a yard? A fence? A swing? Flowers? Trees? A lawn?
17. If you moved during your childhood, tell where and when and what you can remember of each house and the family circumstances and reasons for the move.
18. As a child, did you have a room of your own, or did you share it with someone else? If so, whom?
19. Did you have a bed of your own?
20. In what room did you eat? Kitchen? Dining room?
21. Where did you eat when there was company?
22. Did your house have a parlor? Was the family allowed to use it?
23. How was your home heated? Was it warm in winter? Explain.

24. Did you have a fireplace?

25. What kind of kitchen stove did your parents cook on?

26. Did you burn wood? Coal?

27. Did you have to buy the fuel or was this a chore, such as cutting wood, with which you had to help?

28. Did you always have indoor plumbing? If not, when did you get it?

29. Did you always have electricity? If not, when did you get it?

30. Did you ever use candles or kerosene lamps? Whose job was it to fill the lamps and replace the wicks?

31. Did your family have a cellar? Where did you store apples, potatoes? Canned foods?

32. Did your family always have a refrigerator? If not, what did you use instead? When did you get a refrigerator?

33. Where did your family get water? Was it plentiful? What methods were used to conserve water?

Family relations, responsibilities, conditions

34. What was your position in the family? Oldest? Youngest? Were there any advantages? Disadvantages?

35. What were your duties as a small child? Describe your responsibilities as you grew older.

36. Who cooked the meals? Who did the ironing?

37. Did you buy or make your own clothing? Who was the family seamstress? Who repaired the family shoes?

38. When did you learn to cook? Who taught you?

39. Did you learn how to sew? Crochet? Knit? Embroider? Who taught you?

40. Did you ever learn the mechanics of a car? Who taught you?

41. Did your parents keep in touch with distant family?

42. Did you visit relatives often? Near? Far?

43. How did you get your mail? How often?

44. Did you have any childhood diseases?

45. What do you remember about family pets?

46. Were you especially close to anyone in the family?

47. How did the family spend its evenings?

Family income and livelihood

48. What did your father do for a living?

49. Did your mother ever work outside of the home?

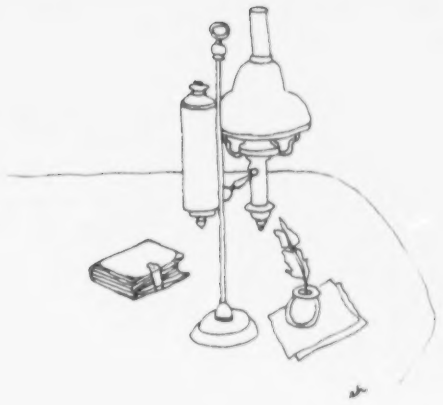
50. Did you contribute to the family income? In what way?

51. Did you get any allowance as a child? Or did you have to earn your own spending money? If so, how?

52. When did you get your first job outside of the family?

53. Did your family have a garden? For family use or profit?

54. Who did the planting? Digging? Cultivating? Weeding? Watering?



55. What kind of vegetables did you grow? Who harvested them?

56. Did your family have fruit trees?

57. Who did the canning and what vegetables and fruits were canned? How?

58. Did you raise hogs or chickens? Cows?

59. What kind of meat did you eat? How often? Did you slaughter your own animals? How often?

60. Did you keep a cow for milk?

61. Did you make your own butter? Cheese?

62. Did any of the family sell eggs or butter?

63. If you lived on a farm, what crops were planted?

64. Who did the work? Family? Hired hands? On what occasions?

Days, seasons, and special occasions

65. What did Saturday mean to you?

66. Was Saturday night bath night? Where? How?

67. What did Sunday mean to you?

68. Did you attend church on Sunday? Alone? With your parents or family or friends?

69. Where did you attend church or Sunday school?

70. Did you have special shopping habits at Christmastime? Did you earn your own money to buy presents?

71. How did you spend Christmas? Describe. Did you decorate a Christmas tree? Did you exchange gifts?

72. What kind of gifts did you receive at Christmas?

73. Did your family observe Easter? In what way?

74. How did you observe the Fourth of July? Where?

75. How was your birthday celebrated? Did you have a birthday cake?

76. What kinds of gifts did you receive on your birthday?

77. Did your family entertain often? What were the occasions?

78. Did your family attend picnics? Family reunions? What do you remember about them?

79. How did you keep cool in summer?

80. Did you go barefoot in summer?

81. What did you wear in winter to keep warm?

82. Do you remember any blizzards or tornadoes or floods?

83. How did these events affect the neighbors, relatives, or town? How did they affect you?

Friends and Games

84. What did you do for recreation?

85. Did you or your brothers or sisters have any hobbies? If so, what?

86. Who were your playmates?

87. Who was your best friend?

88. What did you and your friends do when you got together?

89. Did you and your playmates play any organized games? Football? Baseball? Hockey? Kick the can? Describe.

90. Did you ever learn to swim? Where?

91. Did you ever attend a taffy pull? Pop corn?

92. Did you participate in 4-H or scouting organizations?

School

93. Where did you go to school?

94. Did you ever attend a one-room schoolhouse? Describe.

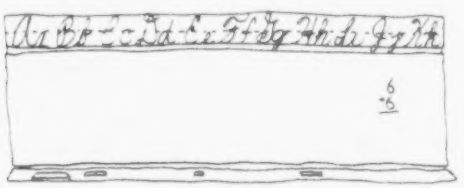
95. How did you get to school? If you walked, how far?

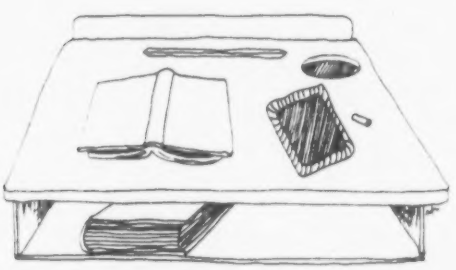
96. What do you remember about these walks? Did you walk alone or with friends? Did you encounter animals that you befriended or that frightened you?

97. Were these walks a hardship in winter? In summer or hot weather?

98. How large was your school in the elementary grades, first through fourth? Fifth through eighth? Eighth through twelfth?

99. What recreation was provided or allowed during periods of rest or recess?





100. Were you helped by older students or did you help others with their lessons?

101. What kinds of grades did you get? What were your favorite subjects? Who were your favorite teachers?

Transportation and surroundings

102. Describe the size of the town where you lived or shopped.

103. Where did your parents shop? How often?

104. How large or how small were the stores?

105. If you lived in a small town or on the farm, did you ever go to the city to shop? Describe.

106. What was the largest town you remember visiting when you were young? What did you do there?

107. Did you ever travel on a train while you were young? What was the occasion? Where did you go and with whom?

108. Were you ever away from home as a child?

109. Did you or your family own a horse? A buggy? Were you able or allowed to ride?

110. When did your family acquire its first car? What make? How much did it cost?

111. When did you learn to drive a car? Who taught you?

112. Where did your family go on vacations?

Outlook

113. Whom did you most admire when you were young? Within the family? In public life? Why?

114. Did you choose someone to pattern your life after? Who and why?

115. When you were small, what did you hope to do when you grew up?

HIGHER EDUCATION AND CAREER

116. What education did you get past high school? Did you study in your adult years?

117. When did you finally settle into your career?

118. Did your family support, oppose, or encourage you?

119. While you were in college or in training, did you live away from home? For how long?

120. Who influenced you most and helped you to develop your skills?

121. How many different employers have you worked for? What promotions have you received?

122. Would you choose the same career if you had it to do over?

MARRIAGE AND LATER LIFE

123. When and where did you meet your husband or wife?

124. How and when did you get engaged? Married?

125. Where did you marry and who was present?

188

126. Did you go on a honeymoon?

127. Where was your first home?

128. What is your spouse's occupation?

129. How many moves have you made during your married life? Where and why?

130. Where and when were your children born?

131. What can you remember of their baby days and childhood?

132. Did you or your spouse go into military service?

133. If your husband went into service, what did you do while he was away? Where did you live?

134. What memories do you have of war years?

135. How has your health been through the years?

136. Did you have animals or pets or recreational equipment?

137. Who have been your closest friends through the years?

138. To what organizations have you belonged?

139. Have you been politically active during your lifetime?

140. Which political party or parties did you belong to, and why?

141. Which presidents have you voted for, and why?

PHILOSOPHY AND OUTLOOK

142. Do you have a philosophy of life to share with your descendants?

143. Do you have a favorite philosopher, teacher, or writer who best expresses your philosophy?

144. Do you have religious leanings or strong religious beliefs?

145. What are your favorite biblical passages?

146. What do you have to say about all the changes that have taken place within your lifetime?

a. The proliferation of consumer goods? Freezers? Dishwashers? Dryers? Electric stoves? TV sets? Radios? Cars? Power tools?
b. The changes in men's and women's fashions?
c. The revolution in transportation and communication?
d. The struggle for the political and civil equality of minorities and women?
e. The technological breakthroughs in industry, medicine, and space exploration?

147. In your opinion, which have been the greatest advances or inventions of all?

148. What things have given you the most pleasure or satisfaction? Your family, home, career, possessions, hobbies? Man's increased mobility and knowledge concerning himself, the world, and the universe? The hope for improved race relations and for world peace?

149. Is there anything that has caused you perpetual concern? What events or trends have disturbed you most in your lifetime?

150. What things do you fear most in regard to future generations? Where are the greatest inherent dangers?

151. How would you encourage or counsel future generations on the following:

a. Marriage and the home?
b. Obligations to country and society?
c. Traits such as honesty, humility, perseverence, diligence, thrift, loyalty, reverence, kindness, faith?
d. Care of body, mind, and health?

152. What has been your experience in regard to the following:

a. Answers to prayers?
b. Necessity and power of love?
c. Will power as opposed to being ruled by one's feelings?
d. ESP
e. Inner peace and tranquility?

153. What do you consider to have been your most important achievements?

CHECKLIST: BE SURE YOU INCLUDE THE FOLLOWING INFORMATION:

1. Your birth date, place, parents, surrounding circumstances and conditions.

2. Your brothers' and sisters' names, dates of birth, dates and places of marriage, spouses' names and children.

3. Your marriage: to whom, when, and where.

4. Family moves: when, where, and why?

5. Your career: training for your job, promotions, employers you worked for, salaries, associates, achievements.□

Virginia Allee is engaged in a variety of genealogical research, writing, and publishing projects. Most recently she published *Grandmother Grosvenor's 1827 Cookbook* as a family history project.

CONCEPT #6: FAMILY RELATIONSHIPS

Objective 6.1: The student will identify factors that affect intergenerational relationships including grandparenting.

Generalization:

For most older people, families are a significant source of support and identity. Family relationships in later life are characterized by interdependence which allows all generations to satisfy their needs better than they could alone. This is particularly true for the young-old in interaction with their adult children and grandchildren. If the health of an elder should fail, then the family becomes a major source of instrumental and emotional support.

Several factors influence the nature and quality of intergenerational relationships in later life. These include cultural or ethnic patterns; demographic factors (such as income levels and the age and sex of the generations); family history of interaction; family communication and problem-solving skills; and knowledge and attitudes about aging.

Strategies and Resources:

1. Using the reading, "Families in Later Life" (resource section 6.1) have students compare and contrast their own family situations and families they are familiar with to the national norm.

2. View the film "Three Grandmothers" and discuss the cultural differences of aging and intergenerational relationships. Have students from different ethnic backgrounds compare experiences in their cultures. Invite people of different ethnic backgrounds in the community to form a panel and discuss how people live their later years in their cultures.

3. View the film "Peege", "Grandpa Doc" or "On Golden Pond" and identify all the factors that influence the family relationships shown. (See "Peege" Study Guide, resource section 6.1).

4. View the film "Grandpa Doc" and discuss how this relates to the students' own experiences.

Objective 6.2: The student will discuss patterns of family interaction in later life and analyze how these patterns change if the family member's health and/or level of independence change.

Generalization:

Family relationships with older individuals are typically measured on four dimensions: (1) residential proximity (56% of the elderly live within a one-hour drive of one or more children); (2) interaction frequency (over 70% of elderly parents have at least weekly contact with their children); (3) reciprocal assistance (most interactions are characterized by both generations giving and receiving support and aid); (4) the quality of family relationships (families are a unique, durable, and powerful source of emotional and instrumental support for all generations).

If an elder's health status declines, changes often occur in family interaction. Frequency of contact and residential proximity increase and assistance is likely to become more one-directional, with the elder receiving more than he/she contributes. The quality of relationships may be strained as families adjust to new demands and challenges. Nevertheless, family members can learn to meet the demands of these changed relationships. In fact, 80% of in-home aid provided to elders is provided by family members, particularly wives and adult daughters. Unlike the myth of the deserted elder, the reality is a picture of active interaction and support at all life stages.

Strategies and Resources:

1. Using the poem, "My Children are Coming Today," (resource section 6.2), discuss the importance of independence for people of all ages, as one issue affecting relationships.

2. Use the educational game Families and Aging: A Game of Dilemmas and Decisions and the Extension Leader-Teacher Guide (both available from Oregon State University Extension Service; see resource section 6.2). Follow suggestions for activities in the guide. Use the discussion points in the guide and focus on how changes in health influence interaction patterns.

3. Have students read and discuss "The Aging Parent and the Adult Child" (see resource section 6.2). Analyze the different interaction patterns outlined in the readings, relating these to health and independence levels.

4. See the film "On Golden Pond" or "The Mailbox." Discuss how each of the four dimensions of family relationships is shown in these films.

Objective 6.3: The student will develop an appreciation of one's own family and its history and traditions.

Generalization:

At all stages of life, families can provide a significant source of support and identity. Family history and traditions are one source of personal identity. This history can be traced through reminiscence across the generations.

Strategies and Resources:

1. Have students start to trace their own family histories by interviewing parents, grandparents and/or other relatives. Use the reminiscence guide and/or the family history questionnaire in section 5.5 as resources for this activity.

2. Students may compile a history of cars, homes, furniture, the economy, changes in society or other subjects through interviewing parents, grandparents or other adult relatives about changes he/she has seen. Research literature, old newspapers or photographs for illustrative examples.

Objective 6.4: The student will apply a problem-solving process to addressing common situations facing families in later life.

Generalization:

Communication and problem-solving skills are important factors which directly influence the quality of intergenerational relationships. As is true at all stages of life, problems and conflicts may arise that require understanding and skill to resolve. Common age-related difficulties for families include such diverse experiences as the remarriage of a parent, visiting patterns for grandchildren, housing decisions, and caregiving for a frail parent. Through active listening and problem-solving family members can understand one another's views and reach a mutually satisfying solution to difficulties.

Of particular importance when a family is facing the problem of caring for a frail member is the "principle of shared functioning." This principle states that responsibilities for the many aspects of caregiving be divided among family members and other resources, including professionals and service agencies. By distributing the responsibility for care, no one family member becomes the bearer of all care. Carrying heavy caregiving responsibilities without active support from family and/or services may lead to social or health problems for the caregiver. Often family members can help the primary caregiver, particularly a wife caring for a disabled husband, recognize her own needs and call upon others, thus exercising the principle of shared functioning.

Strategies and Resources:

1. Show the OSU Extension Service slide series, "Best Wishes, Edith and Henry" (see resource list) to demonstrate the principle of shared functioning and outline a family problem-solving prccess. Have students apply this principle and process to various cases/situations.

2. Have students read the Oregon State University Bulletin (PNW 246), "Aging Parents: Helping When Health Fails" (see resources section 6.2). Apply the problem-solving method described in the bulletin to some typical situations involving elderly individuals.

Film written and directed by Randall Kleiser

Running time: 30 minutes

For more information about our program, Creative Living Environments in Old Age, contact:

UNITARIAN UNIVERSALIST
SERVICE COMMITTEE (UUSC)

78 Beacon Street
Boston, MA 02108
(617) 742-2120

1251 Second Avenue
San Francisco, CA 94122
(415) 731-3300

176

Printed in U.S.A.

Peege Study Guide

Unitarian Universalist Service Committee

177

Introduction

"Peege" is a deeply affecting film that brings all its viewers face to face with common responses to aging people who can no longer live independently. While watching the film, viewers accompany a middle-aged couple and their sons to a nursing home, where they pay a Christmas visit to their dying grandmother. Though outwardly cheerful, the visit is a troubling experience for all involved, including the film's audience. Through discussion, however, the audience can transform its experience into a positive response to the issues "Peege" raises about caring for those who are old. Through careful consideration of the film's content, the audience should be able to work past a common tendency merely to blame the family for Peege's situation and arrive at more insight into the many issues the film raises about aging.

Part One of the Discussion:

Sharing Initial Responses

After watching "Peege," the audience should be encouraged to share its feelings about the situation portrayed and the people involved. Peege, the members of the visiting family, the residents of the home, the nurse, and the nursing home itself all elicit strong responses that viewers will want to express. The following questions may be helpful in starting the discussion:

1. *How does this film leave you feeling?*
2. *With whom do you identify?*
3. *With whom are you angry or uncomfortable?*
4. *With whom are you sympathetic? Why?*

Part Two of the Discussion:

Observing the Interaction between Peege and Her Family

The most heated reaction to this film is likely to focus on the family's behavior toward Peege. Therefore, it will be helpful to turn first to a discussion of the family members' responses to Peege and hers to them. Watching this interaction will reveal ways in which they all suffer from our society's common attitudes toward aging and the care of frail elderly people. The notes below are meant to provide a context for the incidents and dialogue the audience will recall while analyzing the family's behavior. By no means exhaustive, these suggestions are sure to be supplemented by the audience's own perceptions.

The Family's Conversation with Peege

Why is the family's exchange with Peege so uncomfortable? What attitudes toward old age adversely affect their responses to her?

The Hunters try hard to reach Peege, but seem unable to do so. Naturally, their difficulty heightens the discomfort they feel in the presence of the once-vibrant woman. As their conversation in the car reveals, they are primarily preoccupied with her physical failings—her blindness, her weakness, her general physical decline—and the questions Mr. Hunter puts to her underscore that concern. "Are you hungry, Peege? Are you sleepy?" he asks. These questions, though they express concern, do little to lessen the spiritual distance between Peege and her family. Insofar as they do not solicit

her thoughts or memories, other questions they ask do little more to bridge the uncomfortable distance between Peege's present world and theirs. Perhaps their fear of what she may be suffering prevents Peege's family from inquiring about her thoughts and feelings. Perhaps the infrequency of their visits makes intimacy difficult. Or perhaps they do not ask after her thoughts, as Greg later does, because they are prey to a pernicious assumption that pervades our society, that is, the assumption that mental incapacity necessarily accompanies the physical decline of old age.

Their questions having sparked little response, each family member tells of recent accomplishments and activities. Peege barely acknowledges the reports, and again no feeling of connectedness is generated. Instead, the glaring contrast between the family's recent activities and Peege's existence in the nursing home seems to create even more distance between Peege and her family.

Noting the awkwardness and pain of the family's conversation with Peege, the audience should remember details for purposes of comparison with the personal exchange between Peege and Greg, an encounter which is meaningful to both grandmother and grandson and renews their special bond.

Mrs. Hunter

How does Mrs. Hunter respond to Peege and the nursing home? What past events may be affecting her response?

Behind Mrs. Hunter's overly bright smile and tone may be pain and fear that make it especially difficult for her to be with Peege. As a woman, she may well identify with Peege; certainly she dreads becoming like her. Nevertheless, she does visit and tries as best she can to please the older woman. Though the audience may find them inappropriate, the presents Mrs. Hunter brings do represent her effort to imagine what Peege can still enjoy. And though her tone and comments may seem unfeeling, her behavior reveals the inner struggle she is waging. The audience will remember how she

turns from Peege in tears when the latter is overtaken by coughing. What might those tears mean? Viewers are also sure to note that Mrs. Hunter is the only one who does not kiss Peege as the family leaves. Perhaps this omission is as much an indication of unmanageable emotion as of callousness.

The following two factors may also contribute to Mrs. Hunter's complex response to Peege and should be discussed:

1. Mrs. Hunter appears to be the member of the family who most frequently visits Peege, whereas the more sympathetic character, Greg, has not seen his grandmother for two years. As the regular and responsible visitor, Mrs. Hunter may be under pressures from which Greg is free because of his distance from the situation.

2. Mrs. Hunter may also be suffering from guilt feelings that are exacerbated by seeing Peege in the nursing home. Typically, responsibility for the care of aging relatives is shouldered by the middle-aged women of a family. If Mrs. Hunter has assumed that role, she may feel that she is to blame for Peege's being in a nursing home.

Greg's Response to Peege

How is Greg able to make meaningful contact with Peege when the others are not?

First, it is crucial to note that Greg believes the infirm woman he sees in the nursing home to be the same woman he has known and loved all his life. Drawing upon memories of Peege as the active, fun-loving grandmother with whom he has had such a wonderful relationship, he is able to respond to her with grateful love. He shares those happier times with Peege, helping her to remember her admirable past, and letting her know how much he values what she has been to him. Unlike the others, he wants to know what she is thinking and how she is feeling inside. He touches her affectionately,

and for more than just an uncomfortable moment. He doesn't shy away from her body. To a woman talked at, condescended to, and touched only in the most clinical ways, Greg's caresses, memories, and respect are priceless gifts and ones she clearly enjoys. Note her beautiful smile at the end of Greg's personal visit.

Peege's Behavior

Does Peege's listless response to her family indicate that she is "senile"?

Because Peege is so old, many might assume her to be senile and thus might make no further effort to understand why she behaves as she does and how she might be helped. However, senility is not an inevitable and unchangeable aspect of old age; only a very small percentage of older people experience a severe reduction in mental capacity or change in behavior attributable to normal processes of aging. Instead, behavior such as we see in Peege often has environmental causes, as does such behavior in younger people. The major difference is that a younger person's emotional problems are usually taken seriously and treated. Those of older people, like their illnesses, are often accepted as inevitable and therefore left untreated. Peege has reasons to be depressed, reasons understandable to anyone who imagines him- or herself to be in her shoes. If depression is not a factor in her extremely subdued behavior, overmedication may be. For older people, special care must be taken in prescribing medication and often is not.

Part Three of the Discussion:

Identifying with Peege

Another way to come to grips with this film and the issues it raises is to have its viewers imagine themselves to be in Peege's situation. Since great personality changes are not the unalterable rule of old age, we will all be essentially the same people we are now when we are old, perhaps a little better and wiser. And so, it requires no great imagination to put oneself in Peege's position.

Ask the participants to imagine themselves to have lost their vision and mobility. They should envision themselves as having the same personality and memories they have now, but with less ability to express the former and with no one willing to share the latter. Questions like the following should be raised:

1. How would you react if you lost your prerogative to choose where you will live, how you will live, who you will live with, and how you will spend your time?

2. What would it be like to know that people shy from you because they find old age and old bodies repulsive and frightening?

3. What would it be like to be treated, in your last years, like an unlovable child?

If there are people in the audience who have suffered these experiences, they should be encouraged to share their reactions.

Having vented their own feelings about the film, examined its dynamics closely, and finally put themselves in Peege's position, the audience will probably be more than ready to discuss possible alternatives to what they have seen in the film.

Part Four of the Discussion:

Seeking a Constructive Response to the Film

Knowing that the situation depicted in "Peege" does exist, how do we respond? One way is to help aging people avoid unnecessary placement in nursing homes, to help old people remain in their communities and in as much control as possible of their own lives. Meeting these objectives takes resourcefulness and planning, but is often possible. Help, in the form of homemaking services and home health care, is available in many areas and should be fought for in those parts of the country where comprehensive home care systems are not being implemented as mandated by the Older Americans Act. Housing alternatives other than nursing homes are also possible. For those who do not need constant nursing care, but are unable to live completely independently, one of the many forms of shared living may be an option.

But if home care, shared living, and other alternatives cannot fill the needs of a person in Peege's condition, placement in a nursing home may indeed by the best option. Peege, for example, does not want to return home though she misses it terribly. She knows she'd be lonely there and unable to care for herself. Furthermore, we cannot assume that the family could afford around-the-clock home medical care for Peege. Nor can we assume that Peege would rather live with the family than in a nursing home. Noting the tension of the visit, one can imagine the difficulty of the situation were Peege to live with her family. Almost certainly, most of her care would fall to the one least comfortable with her: Mrs. Hunter. The family may well be emotionally and physically unable to care for Peege at home.

Given that Peege, at the time we see her, may be among the few old people who truly need to live in a nursing facility, the question becomes as follows: How might the quality of

her life there be improved? Imagining oneself to be Peege, one can imagine what one would want. It is important to keep those basic human desires and needs alive—to fight for them to the end of our lives. We all need respect, privacy, power to make choices, stimulating companionship, and activity appropriate to our mental resources, no matter what our physical state.

The following series of questions is meant to stimulate active response to the issues dramatized in "Peege."

1. In what ways does the nursing home depicted in "Peege" neglect the above listed needs? How are the residents treated? In what activities are they engaged? Do they make choices about their lives, or are choices made for them?

   Consider the following incidents and details: a. Mr. Weaver's aborted attempt to converse with the Hunters; b. the residents grouped around a television tuned in to "The Dating Game"; c. the staff's having removed Peege's television upon her becoming blind; d. the residents' being dressed in night clothes during the day, and a holiday at that! Did the residents have a choice in any of the above? Do these occurrences diminish their dignity or reveal assumptions about them that may be false?

2. What would a nursing nome that respected the above listed needs be like?

   Among other things, such a place would: a. encourage residents' participation in decisions affecting their lives; b. support well-trained and respected staff; c. provide secure storage for personal items; d. encourage ongoing interaction with members of the surrounding community, including children; e. provide privacy for visits, whether by phone or in person.

3. What changes in societal attitudes and values would be necessary for such homes to become the norm rather than the rare exceptions?

   Suggestions: Among other changes, our society would have to cease equating young with good and old with bad. Furthermore, we would need to learn to respect, value, and protect those who are no longer able to be productive in clearly marketable ways.

4. What can a church group or individual do to advocate for these changes?

   Suggestions: a. become informed about issues of aging; b. become aware of and support nursing home reform legislation; c. develop relationships with nursing home residents in your community—learn what their needs are and provide appropriate advocacy.

Additional Suggestions

1. Participants in a discussion of "Peege" will all know of old people who have lived out their last years in outstandingly creative and life-giving ways. Talk about these people in order not to leave the impression that Peege's condition is the inevitable fate of old people. Think of Peege in the scenes Greg recalls from his childhood. There we see an old woman overflowing with life and love despite increasing infirmity. That is, even Peege herself can contradict the depressing image of old age that the film presents.

2. It can also be useful to imagine what Greg might do to make Peege's present life better. For example, his ability to see Peege as the person she always was may help him to realize that if she enjoyed music, television, naughty stories, and wine when she was younger, she probably would enjoy them still if they were made available to her. None of these requires sight or mobility to enjoy. Visiting again, Greg might bring the old 78's, a bottle of wine, and a T.V. set tuned in to the channel of Peege's choice. If unable to visit, he might write her frequently, including in his letters memories he shares with Peege as well as news of his present activities.

3. The film's viewers may also want to discuss problems they have faced with their own aging friends or relatives, or in their own experience of growing older. The problems can be discussed in light of the insights the film will have elicited.

Additional Resources

Curtin, Sharon. *Nobody Ever Died of Old Age.* Boston: Little Brown and Company, 1972.

Gray Panthers Manual, Volume II, A Guide for Action. Philadelphia, 1980.

Hess, Beth. *Growing Old in America.* New Brunswick: Transaction Books, 1976.

Nouwen, Henri, and Gaffney, Walter. *Aging: The Fulfillment of Life.* Garden City: Doubleday and Company, 1974.

Study Guide prepared by Susan Tresch-Fienberg

199

FAMILIES IN LATER LIFE

In our society the term family often is applied only to a childrearing couple and their offspring. Does the family cease to exist after the last child leaves, or one member of the couple dies? What characterizes families in later life? Research studies suggest that the family structure changes over the life span of family members (Olson and McCubbin, 1983). The relationships between parents, children and grandchildren expand and contract as a function of their residential proximity and interaction frequency. Most older people report that their families are a significant source of support and identity. The quality of relationships and mutual interdependence or *reciprocal assistance* also measure the connections within a family. These perspectives describe the continuity of family relationships and the functional connections of the elderly person to all family members, from the youngest child to the oldest grandparent (Troll, Miller, Atchley, 1979). The following sections will discuss three major aspects of family life as they relate to aging: intergenerational families; marriage in later life; and the family as caregiver.

INTERGENERATIONAL FAMILY TIES

Family relationships with older individuals are typically measured on four dimensions:

1. Residential Proximity

Fifty-six percent of the elderly live within a one hour drive of one or more of their children. While most older people, particularly couples, prefer to live in their own homes, the likelihood of intergenerational living increases if the older person is female, widowed, over age seventy, in poor health, and/or a minority group member. Fifteen percent of all older women and seven percent of all older men live with adult children. Most multi-generational households consist of *Young-Old* children and *Old-Old* parents.

2. Interaction Frequency

Personal visits, telephoning, and letter writing are common methods of family interactions. A research study of the relationship between elderly parents and children found over seventy percent of elderly parents see one child within a seven day period, and fifty-five percent of older people without children see some relative within a seven day period.

3. Mutual interdependence or reciprocal assistance

Mutual interdependence is characteristic of most intergenerational families. Older parents provide services as long as they are able to do so. Their contributions include babysitting, errands, household assistance, shopping, and care during illness of children or grandchildren.

Older parents become receivers of assistance as their health declines. Sources of help for the elderly are significantly different for men and women. Supportive assistance during periods of illness for non-institutionalized elders indicate the majority of men receive help from their spouse (66 percent) and little assistance from children (15 percent) or self care (10 percent). Conversely, older women receive caregiving from their children (33 percent), self-care (20 percent), or spouse (22 percent).

4. Quality of intergenerational family relationships

Families are a unique and powerful source of emotional support for older people. Interaction with friends and neighbors does not replace family ties. Intergenerational family relationships in later life are influenced by previous relationships, current health status and resources of the elderly, and the adult children's attitudes toward aging and death.

MARRIAGE IN LATER LIFE

The importance of marriage and sexuality does not decrease with advancing years. Older married couples generally report higher levels of marital satisfaction than middle-aged couples (George, 1980). Most older couples express a preference for an independent life

style in their own home, the average married couple generally spends thirty or more years together after their last child leaves home.

Sexual expression is an important part of marriage in later life. Research indicates that seventy percent of men and fifty percent of women are sexually active. The most important predictors of continued sexual activity of older men are good health and a life history of being sexually active. For women, sexual activity in later life is related to their life history, but also having a sexually active partner. Even for those not sexually active in intercourse the importance of touching and closeness is a significant part of sexuality in later life (Kart 1981).

FAMILIES AS CAREGIVERS

Most of the day-to-day care of the frail elderly is provided by family members, particularly wives and adult daughters. Older women often experience a prolonged period of caregiving for an ill or disabled older husband prior to his death. Caregivers typically provide direct personal and home nursing care. Caregivers also assist with transportation, meals, bill paying and maintaining the household. Contact with pharmacists, physicians and arrangements for other professional services is frequently the responsibility of the person providing care.

Caregivers can be supported by family and friends and share the caregiving burden with both time and energy. Formal services of respite care, day care, in-home health and personal care services may be vital to the health of the cargiver as well as supportive of the failing elder. Support groups of peers who can understand the emotional demands of caregving and who offer material aid and advice represent another significant, although informal, support.

Pharmacists should be aware of the important role that family caregivers play in the lives of the elderly and include them in educational efforts. A basic understanding of the social world of older people will enable the pharmacist to interact more sensitively with the elderly and their families. Intergenerational family ties, issues of marriage in later life, and caregiving may influence attitudes toward self-health care and compliance. Thus, the pharmacist needs understanding of and sensitivity to the nature of the family over the life span.

REFERENCES

George, L.K. (1980). Role transitions in later life. Monterey, Ca.: Brooks/Cole Publishing Company, .

Kart, C.S. (1981). The Realities of Aging: An Introduction to Gerontology. Boston: Allyn and Bacon, Inc.,

Olson, D.H. and McCubbin, H.I. (1983). Families: What Makes Them Work. Beverly Hills, CA: Sage Publications.

Troll, L.E., Miller, S.J., and Atchley, R.C. (1979). Families in Later Life. Belmont, CA: Wadsworth Publishing Company, Inc.

OREGON STATE UNIVERSITY
EXTENSION SERVICE

SP 54-064
April 1985

FAMILIES AND AGING

Resources for Professionals

AS PARENTS GROW OLDER: A MANUAL FOR PROGRAM REPLICATION by Alida G. Silverman, Carl Brahce and Carol Zielinski. A manual for developing the "As Parents Grow Older" program, a six-session educational program designed to provide family caregivers with needed knowledge, resources, and skills. (Institute of Gerontology, University of Michigan, Ann Arbor, MI 48109, 1981.)

AGING PARENTS: WHOSE RESPONSIBILITY? by Jane Goz Goodman. Provides lecture outlines, activities, and handouts for a six session program for adult children about aging, parent-child relations, and decisions in later life. (New York Family Service Association of America, 44 East 23rd Street, New York, NY 10010, 1980.)

YOU AND YOUR AGING PARENTS by Lauter, Leah, and Elaine B. Jacks. A "how to" guide for organizing conferences and seminars for adult children about aging-related adjustments and adult child/aging parent relationships. (Adelphi Press, Livermore Hall 103, Garden City, New York, NY 11530, 1978.)

WHEN PARENTS GROW OLD A guide for organizing a film-discussion series for families with aging parents. Discussion guides are included for four films: When Parents Grow Old; Where Mrs. Whalley Lives; 100 Years to Live; and Portrait of Grandpa Doc. (Center for Studies in Aging, North Texas State University, P.O. Box 13438, NT Station, Denton, TX 76203; 1982.)

DEVELOPING A TRAINING PROGRAM FOR FAMILIES OF THE MENTALLY IMPAIRED AGED by Florence Safford. A manual for care providers. Discusses the special needs and problems of families of mentally impaired older adults. Describes in detail a six-week, two-hour per week program for families. (Isabella Geriatric Center, 515 Audubon, New York, NY 10040.)

PARTICIPATION OF VOLUNTEERS, FAMILY, AND COMMUNITY RESOURCES IN PSYCHOSOCIAL PROGRAMS by Lou Ann Mattson, Gayle Boyle, and Kathy Carroll. Discusses formal family programming and methods for involving family members in long-term care facilities. (Ebenezer Center for Aging and Human Development, 2626 Park Ave., Minneapolis, MN 55407; 1978.)

FAMILY INVOLVEMENT IN THE NURSING HOME EXPERIENCE by Betty Meekin. Designed to assist staff in easing the transition of older people from their homes to long-term care facilities. Discusses the family's decision to institutionalize an older relative and the admission process. Includes an example of a visitor handbook. (Center for Studies in Aging Resources, P.O. Box 13438, NT Station, Denton, Texas 76203, 1977.)

Educational programs for farm, forest, family, community, energy, youth & marine audiences

LONG-TERM CARE OF OLDER PEOPLE by Elaine Brody. A practical guide providing information about social work in long-term care facilities and issues of care and treatment. Three chapters focus specifically on services to older people and their families and guidelines for selecting nursing homes, living in long-term care facilities, and relating to institutionalized family members. (Human Sciences Press, 72 Fifth Avenue, New York, NY 10011, 1977.)

FAMILY COUNCILS IN NURSING HOMES by Gayle Boyle and Barbara Kauffman. A guide to developing family councils in long-term care facilities. Includes examples of organizational structure, family newsletter, and family interest survey (Ebenezer Center for Aging, 2722 Park Ave., Minneapolis, MN 55407; 1982.)

MAINTENANCE OF FAMILY TIES OF LONG-TERM CARE PATIENTS by Rose Dobrof and Eugene Litwak. Discusses how to work with residents, families, and the family-less or isolated older adults in long-term care facilities. Provides a theoretical framework for designing and evaluating long-term care policies and programs. Appendix includes suggestions for application forms, interdepartmental memoranda, and a handbook for residents and their families. (U.S. Department of Health, Education and Welfare, 5600 Fishers Lane, Rockville, MD 20857.)

THE EMOTIONAL EFFECT OF PARENTAL INSTITUTIONALIZATION UPON THE FAMILY by Marcela Luise Wentzel. Explores the meaning of institutionalization of family members; family dynamics, particularly between siblings; the family's adjustment to the long-term care setting; and family-staff interactions. (Center for Studies in Aging Resources, P.O. Box 13438, NT Station, Denton, Texas 76203.)

FAMILIES IN LATER LIFE by Lillian Troll, Sheila Miller, and Robert Atchley. A review of the literature on family structure and relationships in later life and a discussion of implications of the data. Chapters focus on older couples, being unmarried in later life, parents and adult children, grandparenthood, and sibling relationships. (Wadsworth Publishing Co., Belmont, CA 94002; 1979.)

FAMILY FOCUSED CARE by Jean R. Miller and Ellen H. Janosik. Combines theory with concepts related to physical and mental health. Focuses on the family as contributing to and being affected by changes in a family member's physical, psychological, or social status. (McGraw-Hill Co., 221 Avenue of the Americas, New York, NY 10020; 1980.)

AGING PARENTS by Pauline Ragan. Collection of 20 papers discussing various aspects of relationships in later years including intergenerational relationships, problems of widowhood, influence of culture, dependency, and relationship issues, and implications for the practitioner. (Ethel Percy Andrus Gerontology Center, University of Southern California, Los Angles, CA 90007; 1979.)

HELPING ELDERLY PARENTS: THE ROLE OF ADULT CHILDREN by Victor G. Cicirelli. Presents results of interviews with older people and their adult children about their perceptions of the amount and type of help needed. Suggestions are given for future social policy and ways to improve helping services. (Auburn House Publishing Company; 131 Clarendon Street, Boston, MA 02116; 1981.)

FAMILY CARE OF THE ELDERLY by Dwight L. Frankfather, Michael Smith, and Frances Caro. An analysis of the Family Support Program of the Community Service Society, New York. Discusses issues involved in home care for the functionally disabled elderly and recommendations for public long-term care policy. (D.C. Health and Co., Lexington, MA 02173; 1981.)

COUNSELING ELDERS AND THEIR FAMILIES by John Herr and John Weakland. A theorectically-based, practical guide for helping families to deal with aging-related problems of elder family members. (Springer Publishing Company, 200 South Park Avenue, New York, NY 10003; 1979.)

FAMILIES AND OLDER PERSONS: POLICY, RESEARCH, PRACTICE by George Maddox, Ilene Siegler, and Dan Blazer. Proceedings of a national conference. Papers discuss the family life of older persons and the implications of changes in kinship relations for future policy, research, and practice. (Center for the Study of Aging and Human Development, Duke University, Medical Center, Box 3003, Durham, NC 27710; 1980.)

HELP FOR FAMILIES OF THE AGING by Carol Pierskalla and Jane Heald. Includes a workbook (eleven structured lessons) and three, sixty-minute cassette tapes. Designed for independent use by small groups of family caregivers to help them deal with emotional responses to changes in relationships and aging relatives; identify solvable problems; generate alternative actions and determine which action is most appropriate for their situation. (National Support Center for Families of the Aging, P.O. Box 245, Swathmore, PA 19081; 1982.)

PSYCHOLOGICAL DISTRESS IN AGING: A FAMILY MANAGEMENT MODEL by Donna R. Eyde and Joy A. Rich. Focuses on the family as a treatment milieu in meeting many secondary mental health needs of aging and as a case manager of services. Family-centered treatment approaches are discussed and evaluated. (Aspen Systems Corporation, 1600 Research Blvd., Rockville, MD 20850; 1983.)

SOCIAL WORK PRACTICE WITH THE FRAIL ELDERLY AND THEIR FAMILIES by Barbara Silverstone and Ann Burack-Weiss. Focus is on implementing the auxiliary function model in working with frail older clients and their families. The auxiliary model emphasizes caregiving as a shared responsibility between the natural support system and agency providers. The reader is provided with skills for working with older clients, designing intervention strategies and, assisting families with problem-solving. (Charles C. Thomas, 2600 South 1st Street, Springfield, IL 62717; 1983.)

FAMILY RELATIONSHIPS IN LATER LIFE by Timothy H. Brubaker. Various articles provide a review of research on family relationships in later life and issues concerning the relationship, for example, divorce, retirement, widowhood, and abuse. Practice and policy implications of the research are also suggested. (SAGE Publications, 275 So. Beverly Dr., Beverly Hills, CA 90212; 1983.)

SENIOR RESPITE CARE PROGRAM by Marilyn Cleland. A manual for training substitute care providers to provide respite to family members caring for frail elders. (Senior Respite Care Program, Good Samaritan Hospital and Medical Center, 1015 N.W. 22nd, Portland, OR 97210.)

UNDERSTANDING FAMILIES: A GUIDE BOOK FOR TRAINERS OF NURSING HOME STAFF. A multi-media series of four 2-hour sessions to enhance the interaction of nursing home staff with families. Includes: 1) text for presentation and discussion; 2) video-tape vignettes simulating family encounters with staff; 3) questions to trigger discussion and 4) Overhead transparencies (optional). Topics include: Family involvement in resident's care; the family's emotions; families and values; changing behavior; and staff-family-resident interactions. (Pacific Northwest Long-term Care Center, University of Washington, JM-20. Seattle, WA 98195, 1984.)

ELDERS AND THEIR FAMILIES. A special issue of Generations (Winter 1982) focused on family relationships in later life (Western Gerontological Society, 833 Market Street, Room 516, San Francisco, CA 94103.)

Prepared by

Vicki L. Schmall, Ph.D.
Extension Gerontology Specialist
Oregon State University
Milam Hall 161
Corvallis, OR 97331

OREGON STATE UNIVERSITY EXTENSION SERVICE

Extension Service, Oregon State University, O. E. Smith, director. Produced and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914. Extension work is a cooperative program of Oregon State University, the U.S. Department of Agriculture, and Oregon counties. Extension invites participation in its programs and offers them equally to all people.

OREGON STATE UNIVERSITY
EXTENSION SERVICE

SP 54-063
April 1985

FAMILIES AND AGING

Resources for Families

ACTION WITH THE ELDERLY: A HANDBOOK FOR RELATIVES AND FRIENDS by Kenneth Keddie, a Scottish author. Although discussion of programs is not applicable to the United States, families should find most of the information helpful. Offers suggestions to help the older person to be independent and to ease the work of the caregiver. (Pergamon Press Maxwell House, Fairview Park, Elmsford, New York, 10523, 1978.)

AGING IS A FAMILY AFFAIR by Victoria Bumagin and Kathryn F. Hirn. Excellent handbook for both the middle-age and older generations. Covers all aspects of aging and intergeneration communication. (Thomas Y. Crowell, 666 Fifth Avenue, New York, NY 10019; 1979.)

AGING PARENTS AND DILEMMAS OF THEIR CHILDREN by Bert Kruger Smith, Jacqueline LeLong, and Bettina Adelberg. A 26-page bulletin presenting general information about family adjustments in later life, nursing home placement of an elder, and the design and content of a discussion series for families. (Hogg Foundation for Mental Health, University of Texas, Austin, TX 78712; 1981; Single copies available free.)

ALZHEIMER'S DISEASE: A GUIDE FOR FAMILIES by Lenore S. Powell and Katie Courtice. Provides an understanding of Alzheimer's Disease and the behavior of the afflicted person. Offers guidance for families. (Addison-Wesley Publishing Co., Reading, MA; 1983).

CARING FOR YOUR AGED PARENTS by Earl and Sharon Grollman. Using a prose format, provides concise information and insights on aging related problems faced by families. Does not provide in-depth information. Offers few solutions to problems. (Beacon Press, Harper and Row, Keystone Industrial Park, Scranton, PA 18512; 1978).

CUTTING LOOSE by Howard M. Halpern. A guide for adults of all ages who experience difficulty in their interactions with parents. Provides understanding and suggestions for dealing with parents who give double messages; play a "martyr" role; rule through fear and belittlement; are unloving; criticize continuously; are seductive; or create conflict in relationships. Emphasizes the importance of distinguishing old relationship patterns from the need of aging parents to be dependent on adult sons and daughters. (Bantam Books, New York, 1981).

FOR GRANDPARENTS: WONDERS AND WORRIES by Myron and Mary Maddon. Discusses the grandparent/grandchild relationship, how grandparents can support their children in the parenting role, and intergenerational living. Has a religious orientation. (The Westminister Press, 925 Chestnut St., Philadelphia, PA 19107; 1980.)

HELP FOR FAMILIES OF THE AGING by Carol Pierskalla and Jane Heald. Includes a workbook (eleven structured lessons) and three, sixty-minute cassette tapes. Designed for independent use by small groups of family caregivers to help them deal with emotional responses to changes in relationships with aging relatives; identify solvable problems; generate alternative actions and determine which action is most appropriate for their situation. (National Support Center for Families of the Aging, P.O. Box 245, Swathmore, PA 19081; 1982.)

Educational programs for farm, forest, family, community, energy, youth & marine audiences

HOME CARE OF THE ELDERLY by Julie Trocchio. Gives basics of home nursing care, guidelines for deciding whether or not to provide home care, and methods for managing health conditions of older adults. (CBI Publishing Company, 51 Sleeper Street, Boston, MA 02210; 1981.)

I LOVE YOU BUT YOU DRIVE ME CRAZY: A GUIDE FOR CARING RELATIVES by Ann Calder and Jill Watt. A basic manual for caregivers. Suggestions given for coping with problems, choosing doctors, involving others in caregiving, and selecting care facilities. Emphasizes the importance of caregivers meeting their own needs. Includes questionnaires and work sheets for self-evaluation and decision making. (Fforbez Publications, 2133 Quebec St., Vancouver, Canada V57; 1981.)

NURSING HOME PLACEMENT: A GUIDEBOOK FOR FAMILIES by Marty Richards, et. al. Examines the many issues families need to consider when an older person can no longer live independently. Topics include assessing the advisability of nurisng home placement, financing, adjusting to life in a nursing home; making visits enjoyable, and working with staff (Pacific Northwest Long-Term Care Center, University of Washington, JM-20, Seattle, WA 98195, 1984).

TAKING CARE OF OLDER PEOPLE AT HOME by John Agate. A guide for caregivers. Discusses management of problems such as disability, communication, mental illness, incontinence, and death. (George Allen and Unwin, 198 Ash St., Reading, MA 018671; 1979.)

THE BEST FRIEND YOU'LL EVER HAVE by Bernard Sloan. The author shares his experience of his aged mother living with his family and explores generational problems. (Crown Publishers, 1 Park Avenue, New York, NY 10016; 1980.)

THE OTHER GENERATION GAP: THE MIDDLE AGED AND THEIR AGING PARENTS by Stephen Z. Cohen and Bruce Micnael Gans. Discusses older parent/adult child relationships, age-related changes, ways adult children can effectively assist older parents, and issues of independence/dependence and institutionalization. (New Century Publishers, Inc., 220 Old New Brunswick Road, Piscataway, N.J. 08854; 1978; $10.95.)

THE 36-HOUR DAY by Nancy Mac and Peter Rabins. A comprehensive guide for families caring for a person with Alzheimer's Disease or other dementing illness. Practical advice given for all aspects of home management and guidance given for choosing a long-term care facility. (John Hopkins University Press, 3400 N. Charles, Baltimore, MD 21218; 1982.)

UNDERSTANDING AGING PARENTS by Andrew and Judith Lester. Examines the adult-child/aging parent relationship and offers practical advice for dealing with one's own feelings and those of one's parents. Primarily focuses on physical and mental changes, death, loss, and grief, and decisions about living arrangements in later life. Has a religious orientation. (The Westminister Press, 925 Chestnut Street, Philadelphia, PA 19107; 1980.)

WHAT DO I DO? by Katherine L. West. A practical guide designed to help families understand the needs of nursing home residents. Suggestions given for caring for, comforting, and communicating with institutionalized, older family members. (Amata Graphics, P.O. Box 12313, Portland, OR 97212, 1981.)

WHAT HAPPENED TO MY MOTHER? by Henry Edwards. A personal account of one family's experience in dealing with mental illness in their 62-year-old wife and mother. (Harper and Row, 10 East 53rd Street, New York, NY 10022; 1981.)

WHAT SHALL I DO WITH A HUNDRED YEARS? by Avis Jane Ball. One woman's experiences in caring for her 90-year-old father. (Potentials Development for Health and Aging Services, Inc. 775 Main St., #321, Buffalo, NY 14203; 1982.)

WHEN YOUR PARENTS GROW OLD by Jane Otten and Florence Shelley. Provides resources and information for coping with the problems of aging parents. Topics include finding help in the community, money matters, diseases of older people, behavior changes, and selecting a nursing home. (Funk and Wagnalls Company, c/o Harper and Row, 10 East 53rd St., New York, NY 10022; 1976.)

YOU AND YOUR AGING PARENT by Barbara Silverstone and Helen Hyman. One of the most complete books on the subject of helping the adult children faced with problems of aging parents. Provides detailed information about community and institutional sources of help. (Pantheon Books, Random House Publisners, 400 Hahn Road, Westminster, MD 21157; 1981.)

Prepared by

Vicki L. Schmall, Ph.D.
Extension Gerontology Specialist
161 Milam Hall
Oregon State University
Corvallis, OR 97331

OREGON STATE UNIVERSITY EXTENSION SERVICE

Extension Service, Oregon State University, O. E. Smith, director. Produced and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914. Extension work is a cooperative program of Oregon State University, the U.S. Department of Agriculture, and Oregon counties. Extension invites participation in its programs and offers them equally to all people.

OREGON STATE UNIVERSITY EXTENSION SERVICE

SP 54-065
April 1985

FAMILIES AND AGING

Media

Educational Game

FAMILIES AND AGING: A GAME OF DILEMMAS AND DECISIONS An educational game during which players confront problems, dilemmas, and decisions families face in the later years. Includes a game board, instructions, playing pieces and 25 cards in each of seven card sets: Health, Money, Parent-Child, Living Arrangements, Death, Relationships, and Dialogue. Players are cast in a variety of roles--older parent, adult child, spouse, grandchild, brother, sister, or other relative. Roles change with each turn.

The game gives students and people who work with older adults a greater understanding of the family dynamics and decision making in later life and a basis for working more effectively with families. The game is a non-threatening way for families to express their concerns about aging relatives and gives them insight into the behavior and feelings of other family members. (Oregon State University Extension Service, Ag. Fiscal and Personnel, Ag. Hall, Room 136, Corvallis, OR 97331, 1982, $20 plus postage.)

Audio Visual

BEST WISHES EDITH AND HENRY (18 min/slide tape/color/1984). Presents one family's story about adjustments and decisions adult sons and daughters and aging parents face in later life. Encourages the viewer to explore the range of alternatives that exist in resolving any particular problem. Specific guidelines are given which apply to nearly any decision families may face when a parent becomes dependent. (Shawn Hausman, American Council of Life Insurance, 1850 K Street, NW, Washington, D.C. 20006.)

CHILLYSMITH FARM (16 mm/55 min/color/1981). A family's documentary of the final illnesses and deaths of their two grandparents and the birth of a great granddaughter. Emphasizes the struggles and rewards of the family providing care at home to the grandparents. The film received the highest reward at the 1981 White House Conference on Aging (Filmmakers Library, Inc., 133 East 58th Street, New York, NY 10022).

WOMEN WHO CARE: LIVING WITH DISABLED HUSBANDS (3/4" videocasseqte, 1/2" reel-to-reel, VHS, Beta/19 min/color). A documentary of the problems and experiences of one woman providing care to her husband and community programs serving the couple's needs. Presents four examples of support and respite services: (1) A wives support group; (2) Adult day care; (3) Home care; and (4) Overnight respite (Marine Community Video, Corte Madena, CA 97925).

WHAT SHALL WE DO ABOUT MOTHER? (16 mm or video/49 min/color). A CBS documentary about two middle-class families as they make emotional and financial decisions about living arrangements for their aging parents. (Carousel Films, 1501 Broadway, New York, NY 10036).

Educational programs for farm, forest, family, community, energy, youth & marine audiences

WHERE DO WE GO FROM HERE (16 mm or video/9 min/color). Portrays a family making decisions about living arrangements for an aged parent. Presents different problem-solving strategies and contrasting family dynamics. Includes a leader's guide. (Educational Development Center, 55 Chapel Street, Newton, MA 02160.)

THINGS ARE DIFFERENT NOW (14 min/slide-tape/color/1981). A true-to-life situation showing "Dad" speaking about his needs and the "family" organizing care so Dad can continue to live alone. Covers pertinent issues such as change in caregiving, preservation of an older person's sense of independence, and the family working with professionals to insure care. (Frail and Impaired Life Support Systems Project, Federation for Community Planning, 1001 Huron Road, Cleveland, Ohio 44115.)

100 YEARS TO LIVE (16 mm/29 min/color/1981). A study of two generations in crisis. A 100-year-old woman and her 80-year-old daughter are followed from home to a nursing home, and eventually, the daughter to a state hospital. (Edward Feil Productions, 4614 Prospect Avenue, Cleveland, OH 44103.)

WHERE MRS. WHALLEY LIVES (16 mm or video cassette/28 min/black and white/1968). Present day-to-day strains and conflicts that can arise between generations living together. Mrs. Whalley is an aging woman who makes her home with her son's family. (National Film Board of Canada, 1251 Avenue of the Americas, 16th Floor, New York, NY 10020.)

WHEN PARENTS GROW OLD (16 mm/15 min/color/1972). An edited segment from the film, I Never Sang For My Father. A man, about to marry, is faced with the problem of a suddenly widowed father whose health is failing. (Learning Corporation of America, 1350 Avenue of the Americas, New York, NY 10019.)

BLOOMERS (16 mm or video/27 min/color/1980). Focuses on the relationship between an adult daughter and her aging mother. (Coronet Films, 65 South Water Street, Chicago, IL 60601.)

PORTRAIT OF GRANDPA DOC (16 mm or video/28 min/color/1977). Greg, a young artist preparing for his first one-man show, reflects on his childhood and his relationhsip with his grandfather. Focuses on how Grandpa Doc influenced Greg's development as an artist. (Phoenix Films, 470 Park Avenue South, New York, NY 10016.)

THE MAILBOX (16 mm/24 min/color/1976). Follows an older woman on her daily trips to the mailbox looking for letters from her children who live in distant cities. Although slanted in the favor of the aged mother, the film points out the lack of contact some elders have with their adult children. (Audio Visual Services, Brigham Young University, 290 Herald R. Clark Building, Provo, UT 84602.)

PEEGE (16 mm/28 min/color/1974). A family's Christmas visit to Grandma who lives in the nursing home. Focuses on the feelings of various family members about the visit and their communication with Peege. (Phoenix Films, 470 Park Ave. S., New York, NY 10016.)

MAKING VISITS COUNT (slides and audio-cassette/color). Provides experiential instruction on how people can enhance their visits with family members and friends who live in nursing homes. An accompanying guidebook is available. The guidebook discusses where, when, how long, and how to visit. (Wisconsin Vocational Studies Center, University of Wisconsin, 964 Educational Sciences Building, 1025 West Johnson Street, Madison, WI 53706.)

SOMETHING FOR FAMILIES (slides and audio cassette/color). Directed to social service and health professionals. Shows how to develop and conduct family support groups for families of nursing home residents. Presents an overview of the model developed at Marion Catholic Home, Milwaukee, Wisconsin. Leader guide also available. (Wisconsin Vocational Studies Center, University of Wisconsin, 964 Educational Sciences Building, 1025 Johnson Street, Madison, WI 53706).

CARING FOR AGING PARENTS This 30-minute color film shows four different families dealing with the question, "How do we provide care for mother or father?" The answer is different for each of them. Done in documentary style, CARING does not so much try to provide answers as it does to give people permission to ask the right questions and to feel the ambivilent and often painful feelings surrounding these questions. Terra Nova Films, Inc. 17832 67th Avenue, Tinley Park, IL 60477.

WHERE DO WE GO FROM HERE? A 9-minute color film designed to improve family members' coping skills while caring for a frail elder who can no longer live alone. A 44-page leader's guide accompanies the film. Cost is $125 for 16mm and $95 for 3/4" video. (Education Development Center, Inc., Customer Service Center, Suite 701, 55 Chapel Street, Newton, MA 02160.

Plays

YOU DIDN'T KNOW MY FATHER by Barbara Kay Davidson. A waiting room of an intensive care unit in a hospital brings together persons with different approaches to impending death. Emphasis is on the family's experience during the dying of a loved one, the doctor's obligation to the family, and the patient's rights. (Plays for Living, Family Service Association of America, 44 East 23rd Street, New York, NY 10010.)

THE ROOM UPSTAIRS by Nora Stirling. A daughter is distrubed about the behavior of her aged mother. Shows some typical problems which arise between elders and their adult children. (Human Relations Aids, 1790 Broadway, New York, NY 10019; 1953.)

MY GRANDFATHER, MY SON by Charles A. Smith. A new father struggles with his self-doubts about parenthood. As he reflects on his future with his son, the memory of his earlier relationship with his grandfather brings him a sense of hope. Demonstrates that older persons can make important contributions to the lives of young people. (Charles A. Smith, Human Development Specialist, Cooperative Extension Service, Kansas State University, Manhattan, KS 66506; 1980.)

IS A CHILD A CHILD FOREVER? by Leo Yates. A short socio-drama about the decision to either personally care for or place a relative in a nursing home. (Leo Yates, Family Life Specialist, Cooperative Extension Service, P.O. Box 3567, Las Cruces, NM 88007.)

Prepared by

Vicki L. Schmall, Ph.D.
Extension Gerontology Specialist
161 Milam Hall
Oregon State University
Corvallis, OR 97331

OREGON STATE UNIVERSITY EXTENSION SERVICE

Extension Service, Oregon State University, O. E. Smith, director. Produced and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914. Extension work is a cooperative program of Oregon State University, the U.S. Department of Agriculture, and Oregon counties. Extension invites participation in its programs and offers them equally to all people.

MY CHILDREN ARE COMING TODAY

My children are coming today.
They mean well, But they worry.
They think I should have a railing in the hall. A telephone in the kitchen. They want someone to come in when I take a bath.
They really don't like my living alone.
Help me to be grateful for their concern. And help them to understand that I have to do what I can as long as I can.
They're right when they say there are risks. I might fall. I might leave the stove on.
But there is no challenge, no possibility of triumph, no real aliveness without risk.
When they were young and climbed trees and rode bicycles and went away to camp, I was terrified, but I let them go.
Because to hold them would have hurt them.
Now our roles are reversed. Help them see.
Keep me from being grim or stubborn about it. But don't let them smother me.

- Elise Maclay

Oregon State University
Extension Service

SP 54-035L
Revised October 1982

FAMILIES AND AGING: DILEMMAS AND DECISIONS

Leader Guide

Prepared by

Vicki Schmall
Extension Gerontology Specialist

Supplies for Lesson

- 1 Copy of the educational game, Families and Aging: Dilemmas and Decisions per every 4 to 5 study group members.
- Flip chart, newsprint or other paper to write on.
- Felt tip pen.

Introduction to Lesson

Tell the purpose of the lesson, which is to focus on the problems and concerns adults have about aging relatives, and specifically, aging parents. To be discussed are:

(1) Factors which contribute to quality relationships in later life.

(2) General principles to consider when an older person's health fails or social circumstances change and family members are called upon to provide support and/or to make decisions.

This program is designed to assist family members to be more effective "helpers" to their aged relatives.

Demographic Changes

Share pertinent information about population changes and the implications of these changes for older adults and their families. The major changes include the following:

- Reductions in mortality and fertility have changed the population distribution in the United States. Two of the most dramatic changes in the 20th century have been the increase in the percent of older people and the increase in life expectancy.
- While the total population increased 2½ times from 1900 to 1970, the number of people age 65 and older increased 7 times.

OREGON STATE UNIVERSITY EXTENSION SERVICE

Extension Service, Oregon State University, O. E. Smith, director. Produced and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914. Extension work is a cooperative program of Oregon State University, the U.S. Department of Agriculture, and Oregon counties. Extension invites participation in its programs and offers them equally to all people.

- More than 11 percent of the population is now 65 or older. The Bureau of Census predicts this age group will comprise 14 to 22 percent of the population by the year 2030, depending on future birth rates. In many Oregon communities, older adults already represent 15 percent or more of the population.

- Changes in life expectancy have contributed to this increase in the elderly population. During the twentieth century, life expectancy at birth has increased 25 years. A male born today can expect to live 69 years; a female, 77 years. Predictions are that by the year 2000, male life expectancy will be 74 years; for females, 84 years.

- On the average, a male reaching age 65 today, can expect to live another 14 years; a female, 18 years.

- The fastest growing population group is the "old-old" -- persons 85 and older. Approximately two million people are in this age group today. During the next 20 years, this age group is expected to increase by 200 percent. In general, it is in advanced old age that physical and mental impairments increase, making dependency on others more likely. The health and social service needs of people 85 and older tend to be the most severe of older adults and the most demanding on families. Adult children play a vital role in providing needed services and assistance.

- The number of four and five generation families is increasing. Many families have two generations over the age of 65. Adult children sometimes are in their 60's, 70's, or even early 80's, and adjusting to age-related changes -- retirement, reduced income, health, or widowhood -- and may not be in a position to provide support to their parents. Sometimes the "old" parent is providing assistance to the "old" child.

- Women are more likely than men to be in a caregiving role to their spouses and to aged parents and parents-in-law. Traditionally, adult daughters and daughters-in-law, have been caregivers, but they may not be as available in the future to provide such care because of our mobile society and the increase in female employment.

Activity

Address the following questions to study group members: WHAT ARE YOUR CONCERNS ABOUT YOUR PARENTS, SPOUSE, OR OTHER RELATIVES AS THEY AGE?

- Write responses on a flip chart.

- Summarize those which seem to be of greatest concern. These usually relate to physical and/or mental deterioration of a relative, catastrophic illness; death of a parent, widowhood; moving a parent into one's home; and nursing home care.

Emphasize that many may never encounter major problems. Many parents remain mentally and physically active until their death and do not need assistance from their adult children. For other older persons, health, limited financial resources, or loneliness may present serious problems. And, adult children may find their parents need support at a time when their own lives are the most complicated and their responsibilities the heaviest. Adults sometimes feel pulled in three or more directions -- trying to raise their own children, support a spouse, live their own lives, work, and help their aging parents -- all at the same time.

Stress the importance of each study group member understanding and empathizing with families who are experiencing age-related adjustments and crises. Too often, others are quick to judge another family's decisions or to offer advice. Families who are caring for an older person suffering from dementia (brain deterioration) often find friends withdrawing from them. Yet, this is a time when a family usually needs the most support.

An Educational Game

To introduce the game, ask participants questions such as the following:

- How would you deal with some aging-related family concerns if you encountered them today?
- What would you do if your spouse could no longer drive safely, but insisted on driving?
- What would you do if your mother had a severe stroke and you had only two choices -- a nursing home or your home, with bedrooms already crowded? And, what if your mother has said to you, "I would rather die than live in a nursing home!"
- What would you say if your very ill father said to you, "Here, take my wallet. I won't need it anymore."
- How would you respond if you were an independent 83-year-old and your children told you "You can no longer live alone in your home. We just worry too much about you!"

Tell the study group members they will be playing a game, FAMILIES AND AGING: DILEMMAS AND DECISIONS, to provide insight into such situations, to gain a greater understanding of family decisions in later life, and to generate discussion on how different families might solve the same problem.

While holding a copy of the game board so that it can be seen by all study group members, give instructions for play.

1. Each player throws the die. The player throwing the highest number on the die starts the game.
2. The player rolls the die and moves the number of squares on the game board as indicated on the die.

3. The player draws a card from the set of cards with a symbol corresponding to the square on which he/she has landed.

4. The player reads aloud the situation on the card. Then he/she says what he/she would do if confronted now with the situation. The player also says how he/she feels about the situation.

5. Other players may comment or ask questions before play proceeds to the next player. Interaction among players is encouraged.

6. Play proceeds in a clockwise direction.

7. Players landing on "Pass" lose a turn.

8. Randomly interspersed in the six subject matter cards -- Health, Money, Living Arrangement, Relationships, Parent-Child, and Death -- are cards stating "Draw a Dialogue Card." The player drawing such a card, then draws a card from the "Dialogue" set. On that card, a family role-play situation is presented. Again, the information on the card is read aloud. Two or more players are assigned roles as indicated on the card. These players become a "family" and must act out the situation presented on the card. The remaining players observe.

Have study group members form into groups of four or five. Set the game boards on the tables.

Play the game for 20 minutes.

Post-Game Discussion

State that all of the situations encountered during the game were taken from real life.

Discuss the game and players responses to situations with which they were confronted. Questions such as the following may help to generate discussion and expression of feelings:

- What were the most difficult situations for you? What made them difficult?
- How did you handle those situations with which you felt uncomfortable?
- What did you learn about family relationships and decision-making in later life?
- How does what you experienced in the game apply to your relationships with family members? How can you be more effective in your relationships with older family members?
- What additional information or skills did you find you needed to be more effective in the situations you encountered?

Emphasize the following:

- Each older person and family system is different and unique. There are no easy answers when a parent's physical and/or mental status deteriorates or social circumstances change. The right answer for one family may be totally wrong for another family faced with a similar situation.

- During the game, players may have found themselves asking more questions than finding answers. These are the questions families need to ask, but that too often go unasked because families are only focused on finding "the answer."

Being An Effective Helper

It is not always easy for family members to provide the support and assistance needed by an aged relative. Discuss reasons why families may not provide help. These include:

- Distance and availability of family.

- Past relationships. Not all adult children have had positive relationships with their parents.

- The needs of the older person. The receptivity of the older person to receiving assistance.

- Present burdens. Adults sometimes have financial, health, career, family, or marital problems that make it difficult (or impossible) for them to be supportive.

Discuss general principles in being an effective helper and ways adults can enhance their relationships with aging relatives. These include:

- Understanding the Aging Process. If people know what to expect with age and disease, and the implication of these changes, they will be more understanding and cope better with changes in an aged relative.

- Taking stock of feelings. To effectively help a parent, an adult child must take stock of his feelings toward a parent. Feelings about parents are varied. They may include love, respect, compassion or anger, hostility, fear, and anxiety or indifference. Not all parents are likeable. However, a person can still be an effective helper even if he/she has negative feelings about a parent, but such feelings need to be recognized and resolved. Unresolved feelings can affect an adult child's behavior and result in unwise, inappropriate decisions. When unresolved feelings direct relationships, negative behavior is more likely to result, e.g., oversolicitious behavior -- spending an abnormal amount of time doing for parent; faultfinding with others who are providing care; denial of a parent's problems or need for help; blaming parent for one's difficulties; rebellion; or withdrawal.

Coping with Feelings

The increasing frailty of a parent can be a daily reminder of a parent's mortality and by extension, our own mortality. A change often must be made in our perceptions of our parent. Making this change can be emotionally painful. It is not easy to accept that "my father is no longer the strong and powerful man he once was," or "my mother, who was an excellent cook, no longer knows how to cook."

Expressing such feelings to someone who will listen and understand, often helps lessen the pain. A parent, too, is likely to have similar feelings. It's difficult for most older people who have been self-sufficient to accept any level of dependency. Some, however, expect adult children to fulfill their needs. This is an unrealistic expectation. Parents should be encouraged to discuss such feelings.

Feelings about our parents go back many years. Whatever the lifetime relationship has been with a parent, a crisis is likely to put stress on it, even on the best relationships. Sometimes, however, families do find that crisis brings them closer together. But usually, negative feelings are difficult to resolve under stress.

Communicating Openly

Open and honest communication is a key to building and maintaining effective relationships. Both adult children and their parents all too frequently play games with each other. Adult children sometimes send out messages they feel their parents want to hear or messages that will not upset their parents, rather than what is true. Communication problems may have a longstanding history or be a problem only in times of crisis.

"I messages" tend to open communication," "You messages" sound dictatorial and create defensiveness on the part of the person to whom the individual is talking. With "I" messages, the individual speaks from his/her own personal feelings. An example of an "I message" is: "Mom, I am concerned about your safetly in this house. I have this terrible fear that you may fall and not be found for several hours -- or even days." An example of the less effective "You" message is: "You must move, Mom. This home just isn't safe for you."

Planning Prior To Crisis

Have study group members spend time planning for the part they might play in their relative's old age. Most people don't like to think that their parents (or spouse) someday may not be self-sufficient. As a result, most families are unprepared to handle increased dependency needs.

The best approach is to talk before a crisis develops and discuss the future "what ifs," for example, asking a parent what their wishes would be if they could no longer live at home. Most important is not to have only one plan. Explore options. Circumstances at the time of crisis may be such that the preferred plan cannot be implemented. But, making tentative plans about future possibilities can avoid tragedy and provide some insurance against making unsatisfactory, later regretted decisions.

Talking may not be easy, especially if frank discussions of emotional issues have been avoided in the past. Look for "natural" opportunities to talk. For example, when a parent says, "When I die. . ." do not discourage discussion by statements such as "don't be so morbid," or "you'll probably outlive all of us." Listen, encourage expressions of feelings, and explore the future. The move of a parent's friend to a nursing home or the poor health of another, can be "natural" times for talking.

Involving Older Relative in Decision Making

Older people should be consulted about plans and decisions that involve them. Options are important. Change is anxiety producing, but not being involved in decisions about a change creates even more anxiety. Older people -- even the very frail -- need to maintain maximum control over their lives. Most older people, including the mentally less alert person, can be involved in decision-making to some degree. Unless totally incapacitated mentally, the aged person has a legal and moral right to participate in decisions affecting their lives.

Shared decisions produce the best results. A person who is excluded from decisions is most likely to become angry, demanding, helpless, or withdrawn. And plans are likely to backfire. Involvement in decision-making provides greater assurance that a person will accept and adapt to a change, even if it is not the person's preferred choice. A person who feels railroaded into a new situation usually makes a poor adjustment. Having control over our lives is important to most of us, regardless of age.

When considering "What's best for mom or dad?" be sure to ask what mom/dad thinks is best for herself/himself.

Involving All Family Members Who Will Be Affected By a Decision in the Discussions

Hold a family conference. A family conference can provide a forum for open communication between family members. Siblings, spouses, and other relatives who are concerned and/or affected by the potential decision should be involved. This includes young children who, for example, would be affected by a grandparent moving into the home. A family member should not be excluded because of distance -- communication can occur by telephone -- personality, or limited resources. If the older person is not able to attend the family conference, keep the person informed of the proceedings and involved in the decisions.

Silverstone and Hyman in You and Your Aging Parent (1982 edition) offer an excellent eight-step process for planning and conducting family conferences. Chapter 10 would be particularly beneficial for all family members to read prior to a family conference. The authors emphasize that the process can be defeated by four common roadblocks:

- keeping secrets
- hiding feelings
- making promises
- making hasty, long-term, permanent decisions

Honesty, sharing of real feelings and open communication help to guarantee successful family conferences. If sibling friction, anxiety, or the adult child/aging parent relationship prevents rational discussion, professional guidance should be sought. A professional often can provide an objective assessment, help a family to deal with emotions and conflicts and to become "unstuck." A professional psychologist, social worker, or counselor skilled in working with elders and families may be found through senior centers, hospitals, mental health facilities, or local home health agencies.

Unrealistic expections of family members need to be avoided. Each brother, sister, child, and spouse have an unique relationship with the aged person. Sometimes, individual family members are experiencing stresses in their own lives -- for example a troubled marriage, problems with teenage children, uncertainty about a job -- which may limit the support that can be given. Avoiding judging other family members will often go a long way to building family solidarity.

Exploring Options. Various options should be carefully explored before making any decision. Especially important is not to have preconceived ideas about what is "the best solution." Families too often make decisions based on inadequate information. Area agencies on aging can provide information about local community services and how to access them.

All implications of a change or decision under consideration should be identified. The effect of a decision on the older person and other family members needs to be considered.

Allowing Parent to Risk. Too much loving protection can be deadly for aging persons as well as growing children. The wish to protect an older person who's becoming increasingly frail is natural; however, this is usually the last thing an older person wants or needs.

Overestimating an older parent's needs can be destructive. Taking over functions that the person can still fulfill--even if only with difficulty--is likely to make the person angry, depressed, or more dependent. People resent forced dependency. The goal is to strive for a balance between caring and overcaring.

Before asking or forcing a mentally competent older person to make changes in their life situation, family members need to ask these questions:

- Am I contemplating a protective environment for my parent's sake or my own?
- Are the dangers real or would I just feel more comfortable and worry less knowing my parent is safe?
- Would I feel too guilty if I let my parent take an occasional risk to live independently?
- What does "quality of life" mean to my parent? To me?

Although an older person's safety is important, this isn't the only factor that should be considered in decision-making. It is important to reflect on the type of life the person has lived and his/her feelings about the situation. Equally important is to focus on the person's strengths and remaining abilities as well as their limitations. Too often focus is on only "what mom can no longer do."

Forcing one's values on an aged parent should be avoided. What one thinks is "bad" or "best" for a parent is not always true. Sometimes adult children are focused on a parent's "quantity of life" whereas the parent is focused on "quality of life." If a parent is mentally competent and chooses to remain at home, although adult children feel their parent would be safer in another living situation, that's the parent's right and choice. If concerned, adult children can express their concerns by using "I" statements.

If adult children dictate or overrule a parent, they are likely to suffer the most. Parents have a right to make their own decisions--and to do their own suffering. Adult children aren't responsible for their parent's happiness.

Avoiding Promises. Avoid making promises such as "We'll never put you in a nursing home," or "You can always live with us, Dad." Circumstances may change. Promises that cannot be fulfilled often result in feelings of guilt and mistrust.

When Providing Care

Providing care is stressful, regardless of family commitment. For many, it can be the equivalent of a full-time job or more. Sleep patterns may be altered. Activities may be drastically reduced. Role overload is common. Previous patterns of interaction with the ill person may be reversed.

An adult child may need to assume a parent-like role with their parent. A healthy spouse may need to become more assertive and assume greater control over their partner's life. This can be particularly difficult if the caregiver has been the passive person in the relationship. These role changes can cause fear, conflict, and confusion for everyone. The ill person may resent the burden he/she is creating, and feel anger and frustration in relinquishing roles or become demanding in an attempt to gain some control over the environment that he/she can feel slipping away.

Balancing Responsibilities. Caregivers can easily become caught in a web of trying to meet obligations and responsibilities to the ill person, to other family members and to themselves. Before assuming caregiving responsibilities, the impact of caregiving on everyone should be assessed, including the sacrifices to be made as well as the benefits. Caregiving should not be assumed, for example, at the expense of one's relationship with a spouse, one's own physical and emotional health, or the welfare of the children. Time and energy needs to be available to maintain quality relationships with spouse and children, who may be unintentionally neglected.

Meeting One's Own Needs. People in a caregiving role frequently place their own needs "on the backburner." However, ignoring one's own needs is detrimental to oneself and to the person who needs your care. Providing heavy care and getting little sleep leads to "burnout" -- a bankruptcy of physical, emotional, and spiritual bank account.

Maintaining friendships and planning time for oneself when in a caregiving role is important. Many people feel guilty about leaving the ill person and enjoying themselves because we have been taught that to focus on self-needs when a family member is ill is being selfish. There is nothing selfish about it. Without

respite, caregivers jeopardize their own health, their efficiency and effectiveness fails, and their ability to provide loving care diminishes. Caregivers who become physically and/or emotionally exhausted, increase their susceptibility to illness, decrease their problem-solving ability, frustrations mount, and emotions are more likely to get out of control -- all warning signals of burnout. Leisure time has positive effects on morale and energy. The "I can do it alone" attitude places people at greater risk for physcial and mental illness.

Conculsions

Emphasize there is no one solution to the issues and problems people face in relation to their aging relatives. Each situation must be treated on an individual basis. Most important is that the feelings, desires, and needs of everyone are taken into consideration. Most important is not to let guilt guide decisions. People really need to look at what is best for themselves and their family, as well as for the aged relative.

For some people, answers to difficult situations may require a professional, for example, a counselor, physician, financial advisor, lawyer, or social worker. Involvement in a family support group may help to provide answers to problems of caregiving and also reduce social and emotional isolation. Sharing with others who are living through the same experience can be mutually beneficial and provide a sense of "I am not alone," Support groups also provide a source of venting feelings with others who understand.

At the End of Lesson

- Distribute handouts
- Have each group member complete an evaluation.
- Turn in the evaluations and games to the County Extension Home Economist.

The Aging Parent and the Adult Child

By Sterling E. Alam

As more and more Americans live after the traditional retirement years, public attention has increasingly focused on the relationships between middle-aged adults and their aging parents.

A staff member of the Andrus Gerontological Center has said that up to a quarter of the calls that come into the University of Southern California counselors are from "middle-aged kids" who are having problems with an aged mother or father *(1)*. Newspaper articles on how to get along with aging parents and middle-aged children appear fairly regularly and at least three popular books have been published on the subject *(2)*. Also, both the National Council on Family Relations and the Gerontological Society now have task forces promoting research on this topic.

It is hardly surprising that the relationships between aging parents and their middle-aged children are seen as problematic by both the lay public and social scientists. Middle-aged adults and their aging parents have no clearly defined role expectations *(3)*. Nor can we assume that adults first devote their major attention to their dependent children and then to their dependent parents. It may even be adults' most common experience to be caught in a dilemma between simultaneous demands from both up and down the age scale.

While human development specialists have concentrated on life's early years . . . adult development has far outstripped our theory and research about it.

While human development specialists have concentrated on life's early years and on the generation gap between parents and adolescents, adult development has far outstripped our theory and research about it *(4)*.

This article is designed to stimulate research attention to the area of adult intergenerational relationships and to focus on the interaction that occurs between adults and their parents in extended families.

A Study of Generations

As a state specialist in the Cooperative Extension Service, I developed a lesson on "The Aging Parent and the Adult Child." As part of the lesson, students listed on cards the problems, benefits, and rewards of intergenerational relationships. A content analysis of the cards collected from lessons taught in seven counties provides a look at some of the dynamics of the relationships involved.

The people who wrote the comments were all female, primarily homemakers from small towns and rural communities. Twenty percent of the respondents were over age 65, 55 percent were between 46 and 55, and 25 percent were under age 46. This is by no means a random sample of the U.S. population. It is, however, a "slice" from the heart of a region that is often stereotyped as middle America. The respondents' comments suggest some highly researchable questions.

Problems

The largest number of problems mentioned were what could be called generation gap problems; that is, differences in values, attitudes, and behavior. For example:

"Children feel we should spend more money for modern things which we were never accustomed to and don't especially need or want."

"What I'm finding out about my aging parents and others is that they get so tight with their money when they don't have to be. I don't mean they should give it out to their children, but should spend it on themselves more instead of acting as if they don't have the money to spend for doctor care or things that would make life easier."

Respondents also mentioned as sources of disagreement women's liberation, sex education, and differences in child rearing practices.

The next most common problem was "interference." Parents seemed to continue to try to "run their children's lives," but at their age their children had a marked tendency to try to dominate their parents' lives as well.

"Older people don't want to give adult children the privilege of making decisions without them."

"Now children think they will tell their parents how to live their lives."

A major set of problems involved the adult

The author is a gerontology specialist with the Cooperative Extension Service, University of Illinois at Urbana-Champaign.

Reprinted with permission from Journal of Home Economics.

children's impatience with some of the normal characteristics of aging, such as loss of hearing, sight, memory, and speed. Both generations made comments such as:

"Persons who have a health problem, like hearing difficulty, can cause much distress in a family."

"[It's a problem] trying to get younger people to be more patient with older parents – since their actions and words are slower."

Several adult children asked why older people tend to neglect their health and nutrition. Many were concerned because their parents were bored and inactive. Comments included:

"Won't try new things to occupy their time."

"How does one interest another who has never had hobbies outside of work?"

"My mother-in-law will not walk, exercise, or participate in activities at her retirement home. I fuss with her, trying to encourage her, but she is belligerent. Should I let her alone?"

Several problems mentioned actually were just problems of people relating to and occasionally living with each other. In this category fell different attitudes toward cleanliness, television, and noise and such personal characteristics as stubbornness, selfishness, and alcoholism.

Several cards generalized the problem of "lack of communication." When respondents illustrated this though, it often looked like a struggle for dominance.

"It's hard to communicate with your adult child. They don't want to involve you in what's going on in their lives. Even though you're interested."

"They don't want to listen, think they know everything."

"[It's a problem] trying to present a situation to the elderly – that it's for [their] own good – without hurting feelings."

Many children viewed their elderly parents as "demanding," which is, of course, a relative term. One woman illustrated the bind in which the middle generation often finds itself:

"Often the older generation think they should come before the youngsters and this causes the in-between generation to have to choose. Aren't we responsible for children first and our parents second?"

One frustrated elderly person wrote:

"Children feel we ought to pack up and come see them more often! (They live too far away!)"

Several older people resented "being used as babysitter." Others felt unfairly pressured to continue financial aid.

On the other hand, several children worried about parents who felt unneeded or who refused assistance:

"Why do older parents resent their children doing for them?"

A common result of parents needing help was tension between siblings:

"When there is more than one child the problem is always, who is going to take care of the parents?"

Such a conflict may arise when aging parents change their living arrangements. Adult children often see this change as their decision and responsibility.

"How do you decide when a parent can no longer live alone and convince them of it?"

"Where to put aging parents? In your home or rest home or close to you in a trailer?"

"Mother-in-law cannot live with anyone. What to do! She is 90 years old!"

The aging parents experience their own problems:

"Have sold out home, furniture, etc., gone to nursing home, then wish you were home again, but no one to look after you."

Benefits and Rewards

It is encouraging that the respondents volunteered almost as many positive comments as they did problems. Three topics seemed to dominate the rewards of intergenerational relationships: (1) the value of older persons' experience, wisdom, and practical knowledge; (2) the help generations can offer each other in different areas; and (3) the contribution to family continuity through intergenerational relationships.

The largest set of responses expressed appreciation of the value of older people's experiences. Some comments were:

"You discover the parents are full of

It is encouraging that the respondents volunteered almost as many positive comments as they did problems.

Several comments expressed gratitude for the contribution older persons can make to continuity between the generations. . . .

References

1. Powers, C. "What Should I Be?" *Modern Maturity*, pp. 60; Dec.-Jan. 1976-77.
2. Silverstone, B., and Hyman, H. K. *You and Your Aging Parent*. New York: Pantheon Press, 1976.
3. Bengtson, V. L. *The Social Psychology of Aging*. Indianapolis, Ind.: Bobbs-Merrill, 1973, pp. 22-31.
4. Nye, F. I., and Berardo, F. M. *The Family*. New York: Macmillan, 1973, p. 563.
5. Butler, R., and Lewis, M. *Aging and Mental Health*. St. Louis, Mo.: C. V. Mosby, 1977, pp. 49-50.

See also:

Adams, Bert N. "Isolation, Function, and Beyond: American Kinship in the 1960's." In *A Decade of Family Research and Action*, Carlfred B. Broderick, Ed. National Council on Family Relations, n.d.

Leslie, G. R. *The Family in Social Context*. New York: Oxford University Press, 1973.

Phillips, B. "The Aging in a Central Illinois Community." Urbana: University of Illinois all Homes Council Buildings Research Council, Research Report 62-4, Oct. 1962.

Shanas, E. "Living Arrangements of Older People in the United States." *The Gerontologist* 1: 27-29; 1961.

information. . . . Their experiences are worth listening to, so you may be able to avoid some of the same pitfalls."

"Grandchildren can visit the aging parents to learn of the past and also profit from their wisdom and experiences."

The everyday help exchanged between generations was important to both groups. This help included housework, transportation, babysitting, and availability ("knowing your children are always there to help you when you need them"). Respondents often saw giving help as a privilege. Their comments demonstrated a strong concern for and appreciation of reciprocity.

"It is nice to be able to do something for someone who has done so much for you over the years."

"I help the elderly people because someday I may need help."

Several comments expressed gratitude for the contribution older persons can make to continuity between the generations, especially family continuity.

"Aging parent may be the cohesive factor for keeping a family together."

"It is wonderful to see the love and respect grow between your parents and your children."

"The joy of knowing the parent as an individual (not as a parent)."

"More than one generation lets you see several views of the same problem."

The younger generation also saw their parents as role models for their children.

"Children learn respect for the elderly."

"[Am] preparing my children for the time I am in their grandmother's stage now. Selfishly hoping [that] when it's their turn they will be sympathetic to my aging problems."

The older people are also beneficiaries in these relationships.

"An aging parent feels a closer relationship to the world through the children."

"[Relationships] keep the aged aware of modern trends."

"Being together keeps [older people] occupied and keeps them from being lonely."

Some of the most impressive comments described how the generations can help meet each others' emotional needs. Meeting emotional needs is one of the family's major functions, but it is often a rather precarious one if it must be filled by the fragile nuclear family alone.

"[My] parents are wonderful in giving praise to [my] child's successes. Both are rewarded."

"Grandparents make up for the love and attention we parents seem to slip over [for our own children]."

"[It's good to have] someone to talk to who understands your background."

Apparently, in spite of all the problems, aging parents and adult children gain a great deal from their relationships with each other and frequently are among the most important people in each other's lives.

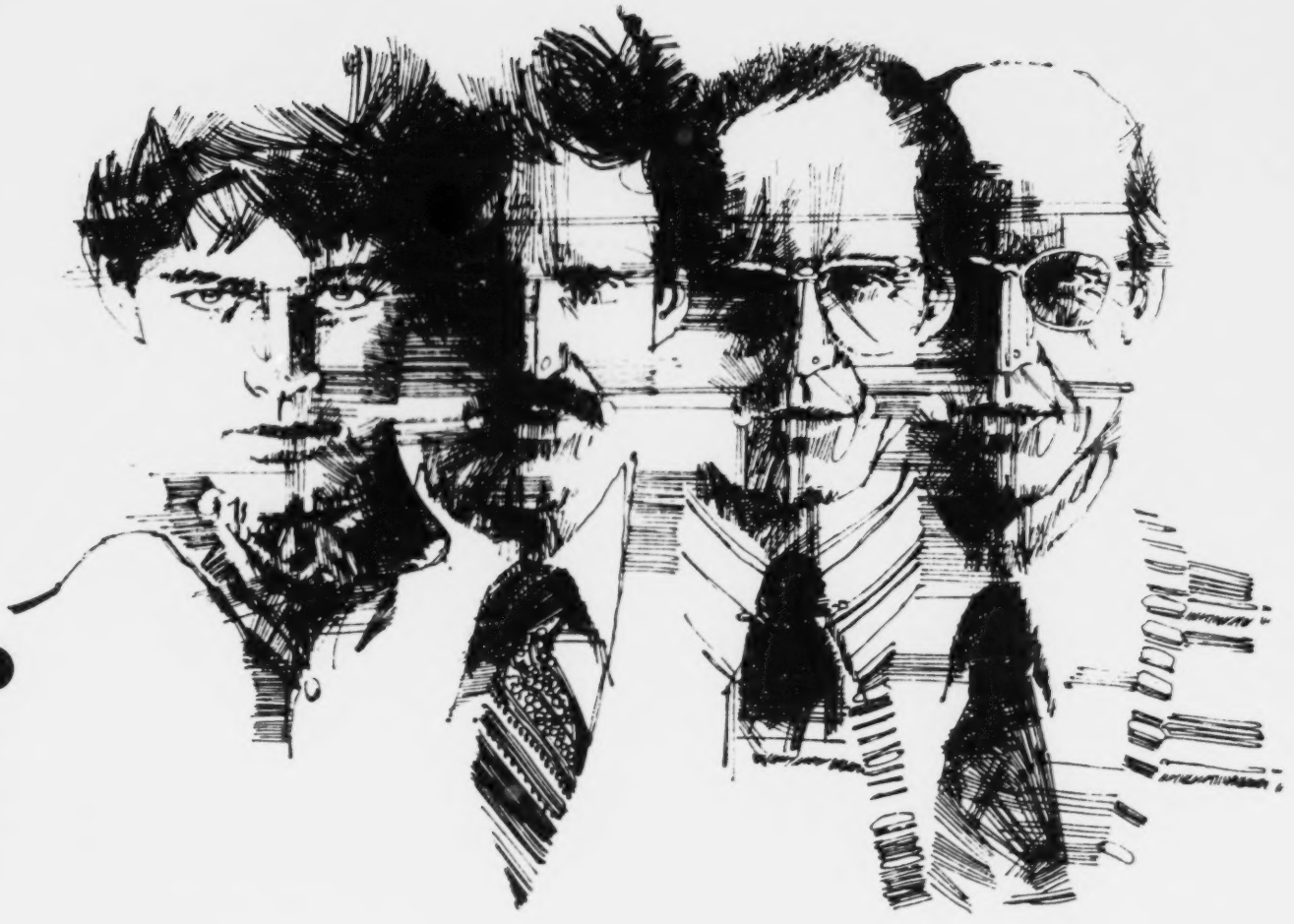
The generation gap between aging parents and adult children seems to be an eminently researchable topic. The lay views expressed in this article need to be more systematically verified to determine their frequency and significance in the general population.

The generation gap also provides an excellent context for testing theories originally formulated to explain characteristics of only one of the generations. For example, Robert Butler's observation of the importance of life review (5) has been widely accepted by gerontologists but little research has been done on it. At the generation gap we can observe life review in action both as a problem and as an opportunity to meet emotional needs and preserve family continuity.

If we now have two generations – the aging parent and the adult child – to explore more deeply, it may be that observing them in interaction with each other will enrich our research on both.

TIPS FOR HEALTHY FAMILY RELATIONSHIPS

1. Understand the aging process
2. Talk and plan before a crisis
3. Involve older person in all decisions
4. Involve any/all extended family members affected
5. Do not make promises
6. Acknowledge feelings regarding parents
7. Do not force your values on parents
8. Allow aging parents to RISK
9. Balance your own obligations and responsibilities
10. Communicate honestly
11. Listen! (especially regarding death)
12. Focus on strengths
13. Meet your own needs
14. Know volatile feelings are normal



AGING PARENTS

Helping When Health Fails

A Pacific Northwest Extension Publication
Oregon • Idaho • Washington
PNW 246 • July 1984

Mother is becoming more forgetful and confused. She doesn't remember to take her medication, doesn't prepare nutritious meals, and forgets to turn off the stove. What can I do?

Should Dad be forbidden to drive? His vision is poor; he's had one minor accident. Still, he seems to drive the four blocks to the store okay.

Mom needs 24-hour supervision. The only choices we have are for her to live with us or in a nursing home. Mom says she would rather die than live in a nursing home. But she and I just don't get along when we live together.

Situations like these are difficult for families. Yet, the decline of a parent's health or intellectual capacities often requires adult sons and daughters to become involved in decisions about a parent's life.

Dealing with such age-related changes in older parents is a relatively new phenomenon. In 1900, for example, only one out of 25 people was age 65 or older; today one out of nine people is in this age group. During this century, life expectancy at birth has increased from 47 years to 74.5 years. A male reaching age 65 can expect to live another 14 years; a female 18 more years.

The most dramatic increase is in the "old-old" population— persons over 85. This is the fastest growing age group and is expected to increase by 200 percent in the next 20 years.

The older people are, the more likely they'll face increasing health problems, frailty, and the need for support and assistance from family and community services. Furthermore, it is no longer unusual for a 65-year-old to have a parent still living.

Many people never face major concerns about aging parents. Their parents remain physically and mentally active until death and need little or no assistance. However, for some older persons, poor health, limited financial resources, or loneliness present serious problems.

Few guidelines exist for dealing with the transitions that occur when a parent confronts age-related changes. Moreover, most of us lack the experience to make the necessary decisions. These decisions are not easy and there are no simple solutions. Each older person and family is unique. The right answer for one family may be inappropriate for another, although the situation and decisions may be similar. There is no "pat answer."

This publication provides general guidelines to consider if you face the dilemma of what to do about aged relatives.

220

before a crisis

Have you spent time planning for the part you might play in your parents' old age? Most of us avoid thinking about the possibility that someday one or both of our parents won't be self-sufficient. As a result, most families are unprepared to handle a parent's increased dependency.

The best approach is to talk with your parents before a crisis develops and discuss future "what ifs." For example, ask your parents what their wishes would be if they could no longer live at home. It's important to explore options and to have more than one plan. Circumstances at the time of crisis may require flexibility. Alternate plans can provide some insurance against making unsatisfactory decisions you'll regret later.

Talking with parents about "what ifs" may not be easy, especially if you and your parents have avoided frank discussion of emotion-laden issues in the past. Look for "natural" opportunities to talk. For example, when a parent says "When I die...," listen and encourage expression of feelings.

Don't discourage discussion by saying things such as "Don't be morbid," or "You'll probably outlive all of us." Other natural times for talking may be when an older family friend suffers a health crisis, enters a nursing home, or moves to the home of an adult son or daughter.

---

coping with feelings

The increasing frailty of elderly parents can become a daily reminder of their mortality (and our own mortality). We may need to adjust our perceptions of our parents. Making this change can be emotionally painful. It's not easy to accept that "my father is no longer the strong and powerful man he once was," or "my mother, who was an excellent cook, no longer desires (or remembers how) to cook." Most painful may be the realization that the parent you depended on is now increasingly dependent on you.

If you can, express your feelings to someone who will listen and understand—a friend, family member, minister, or health care professional. Sharing your emotions can make it easier to deal with the pain.

Remember, too, that your parent is likely to have similar feelings. It's difficult for most people who have been self-sufficient to accept increasing dependency. Any loss of independence or control—qualities highly valued in our society—can be a blow to an older person's self-esteem. Most older people will fight to keep their independence as long as possible. Some will deny or mask their dependency. They'll insist they can manage very well, will refuse any offers of help, or will even attempt to control the lives of other family members.

Encourage discussion with your parent about his or her lifestyle changes and feelings of dependency. Share your feelings; it might help your parent to express his or her feelings. Statements such as the following encourage honest discussion:

> "I'm feeling a little overwhelmed by all these changes, Mother. I can imagine that it's especially painful for you right now."
>
> "It must be difficult, Mom, to leave your home of 40 years and to decide what you'll take to the small apartment and what you'll give away."
>
> "Dad, I know you've always prided yourself on being very independent. I feel it's very difficult for you to ask me for any assistance now that you can't drive anymore. Is that right?"

Regardless of the quality of your lifetime relationship with a parent, a crisis is likely to create stress. Some families find that crisis and increased parental dependency bring them closer together. In other families, unresolved conflicts between the "child" and aging parent revive. Such conflicts are usually difficult to resolve under stress.

Unresolved negative feelings often result in unwise, inappropriate decisions. When unresolved feelings direct relationships, negative behavior often results. Examples of such behavior are:

- Never visiting or contacting parents.
- Being oversolicitous—spending an abnormal amount of time doing things for a parent or creating undue dependency.
- Faultfinding with others who provide care to a parent.
- Denying a parent's problems or need for help.
- Blaming the parent for one's own difficulties.
- Becoming a martyr—making unreasonable demands on oneself and not letting others help with caregiving.

If possible, acknowledge and resolve negative feelings about a parent prior to crisis. Come to terms with early experiences and feelings, forgive a parent for past mistakes, and accept the parent as he or she is today. It often helps to realize that parents are individuals with their own needs, limitations, strengths, and life histories. Most parents have tried to do their best.

You and your parent can improve a poor relationship, but it takes willingness from both generations to try to understand the other, to not judge, to forgive, and to accept each other as adults.

---

crisis: reducing strain

Adults often find an aged parent needs support at a time when their own lives and responsibilities are the most complicated. If you are in your 30's, 40's, or 50's you may feel pulled in several directions—raising your children, being supportive to a spouse, helping aged parents, and/or working—all at the same time. It's not unusual to wonder "Why me?" or to ask yourself, "What about my life?"

If your parent is 80 or older, you are likely to be in your 50's, 60's, or 70's and may be adjusting to your own age-related changes—retirement, reduced income, widowhood, or decreased health—and may not be able to provide the assistance your parent needs.

If your parent's health and/or living situation should deteriorate and you face decisions about your parent's life, the following guidelines may help to reduce the strain.

Communicate openly. Open, honest communication helps build and maintain effective relationships. Oftentimes, family members are not honest or direct enough with each other. Adult sons and daughters don't always tell the truth; sometimes they say only what they think their parents want to hear or what they think won't upset their parents. This tends to create mistrust and wastes energy as family members "walk on ice" with each other.

"I" messages promote communication. With "I" messages, the individual speaks from personal feelings and identifies both the specific behavior or situation of concern and its effects on him or her. An example of an "I" message is, "Mom, because of your recent falls, I'm concerned about your safety living in this house alone; I'm afraid you'll fall again and not be found for several hours—or even days." Mother is much more likely to be willing to discuss the situation if you

communicate feelings directly instead of with a "you" message ("You must move, Mom; this home just isn't safe for you.").

We send people many "you" messages about their behavior. These messages sound dictatorial, create defensiveness on the part of the person to whom we are talking, and create a resistance to change. "You" messages are usually orders or commands ("You must eat;" "Stop doing that;"). blaming or name-calling statements ("You drive me crazy;" "You never cared about me;"), or statements that give solutions or deny a person's feelings ("You should move to a retirement home;" "You shouldn't feel..."). The worst "you" message is the "if...then" threat ("If you don't... then I will...").

Adequately expressing your thoughts and feelings to another person is only one part of effective communication. You also need to actively listen and empathize—sense and understand the feelings and emotional needs of another. The worst thing to say to a person is "You shouldn't feel..." or "There's no reason for you to feel..."

If you listen actively, the person to whom you are listening feels your care and concern. When older parents experience changes and losses, they may experience many feelings—fear, anger, grief, helplessness, and frustration. Having an adult son or daughter who is willing to listen and understand such feelings makes it easier for parents to talk openly about their situation, concerns, and feelings. An example of an active listening response is, "I sense you're feeling angry and disappointed because neither Bob or I came to visit you last week."

Active listening **is not** the answer to long-term problems in a relationship. No one thing can readily solve such problems. Nevertheless, the acceptance that you give through active listening may help to break down old barriers and allow a new relationship to develop.

Inaccurate interpretation of messages often causes needless misunderstandings and conflict between parents and adult sons and daughters. If you receive unclear or conflicting messages, request clarification using statements such as, "I'm not sure what you mean by..." or "Is my understanding of what you said... correct?"

Involve your parent in decisionmaking. When considering what is best for your mother or father, be sure to ask your parent's opinion. Too often the older person is not included in planning and decisionmaking. Family members may fail to tell the person what's happening or the decisions being considered. This contributes to feelings of isolation, helplessness, anxiety, and perhaps despair. Change can cause anxiety, but not being involved in decisions about a change creates even more anxiety.

Shared decisions usually produce the best results. Aged parents have a legal and moral right to participate in plans affecting their lives and to make their own decisions whenever possible. You may not always agree with their choices.

Only if your parents experience reduced mental capacity and/or there is evidence they are endangering the lives of others, should you

question their ability to make decisions. For example, if your father doesn't see well and has had several minor accidents but still insists on driving, then the family has a responsibility to take preventive action. (In certain situations, a family member could be held legally responsible for damage or injury.) In such cases, you may need to dictate or overrule a parent's decision. Do this with kindness and explain the situation honestly to your parent.

If you **must** set limits, involve your parent in decisions about how to implement these limits. For example, say to your father, "Dad, driving isn't a possibility any longer, so what are other ways you might be able to get around?" Work together to identify the choices available to your parent.

To relieve stress between you and your parent, you may want your parent's physician to participate in the decisionmaking. Some people will accept their physician's suggestions more easily than they'd accept the same suggestions if given by a family member.

A parent who is excluded from decision-making is most likely to become angry, demanding, helpless, or withdrawn. Plans are also more likely to backfire. Involvement in decisionmaking provides greater assurance that a person will accept and adapt to a change, even if the change is not the individual's preferred choice. A person who feels railroaded into a new situation usually makes a poor adjustment. Regardless of age, feeling in control of one's life is important.

In the case of progressive mental decline, make plans with your parent as early as possible. Delays in decisionmaking may preclude the elder's active participation in decisions about his or her life. As a family member, you are likely to find the burden of decisionmaking easier if you've discussed plans earlier with the person for whom you must make decisions.

Explore options. Carefully explore various options before making a decision. It's important not to have preconceived ideas about what is "the best solution." Identify all implications of a change or decision under consideration. Consider the effect on your parent, yourself, and other family members.

Evaluate your parent's economic situation. Talking about finances may make you feel uncomfortable and make your relative feel you're meddling; nevertheless, such discussion is crucial to effective planning. Consider your parent's income sources—such as Social Security, pensions, benefits, and income-producing assets—in addition to current and potential expenses.

Inform yourself about possible financial support. It's helpful to know your state laws and regulations concerning assistance in advance of need. Find out what your parent's health insurance policies—including Medicare—cover. Medicaid may be another resource if

your relative receives Supplemental Security Income (SSI) or other public assistance or qualifies as "medically needy."

Contact your local public assistance or welfare office for eligibility requirements in your state. The Internal Revenue Service can supply you with information about tax breaks available to older people and to families who provide care and support to older relatives. Other people who can help you plan for the future are your lawyer and/or tax consultant.

Avoid making irrevocable decisions. Keep options open. Set a definite trial time for any decision and then re-evaluate it. This is sometimes hard to do, especially if you want to resolve a difficult situation and not face more decisions. Approach your judgment from the perspective of "This seems like the best decision for now. Let's see how it works for four weeks. Then we'll reassess the situation."

Too often, families make decisions based on inadequate information. Find out about available community services and how they can help you. Sources for information include senior services divisions; area agencies on aging, information and referral; and senior citizen centers. Don't forget friends and neighbors either. Many are willing to help, especially on a short-term basis.

Know the family's resources. This will help you to evaluate alternatives. Talk with various family members to identify what each can contribute. In one family, for example, the adult children split their mother's chores three ways: one daughter shops; another daughter launders clothes; and a son keeps the accounts and business records up-to-date.

Avoid unrealistic expectations of family members, however. Remember, your brothers, sisters, children, and spouse each have a unique relationship with your parent. Sometimes, individual family members are experiencing stress in their own lives—a troubled marriage, problems with teenage children, uncertainty about a job or finances—which may limit the support they can give. Your perceptions of a family member's situation or assets may not be accurate. Therefore, encourage each family member to share concerns and explore the family resources together.

Don't criticize other family member's contributions; remember that your nonjudgmental attitude may help build family solidarity.

Hold a family conference. A family conference can provide a forum for open communication among family members. Involve the elder, siblings, spouses, and other relatives who are concerned or will be affected by decisions under consideration. Include young children, for example, who would be affected by a grandparent's move into the home.

Don't exclude concerned family members because of personality, limited resources, or distance (use telephone calls or letters to inform and involve anyone who's absent).

It is just as important to include a brother or sister who is argumentative or "never visits or seems to care" in the family conference as the brother or sister who provides financial and/or emotional support. This helps to avoid later undermining of the decision by those not included.

Create a safe environment for expressing feelings and concerns. If possible, hold the family conference in a **neutral** place; don't use the home of the "favorite" child, for instance.

Be honest, share feelings, and focus on the **current** problem— not past rivalries—to open communication for a successful family conference. If anxiety, family friction, or hidden resentments prevent rational discussion, seek professional guidance. A professional can provide an objective view to help your family deal with emotions and conflicts, thus enabling you to identify and resolve problems more effectively.

You can locate a psychologist, social worker, mental health professional, or counselor skilled in working with elders and their families through senior centers, hospitals, mental health facilities, or home health agencies.

Barbara Silverstone and Helen Hyman, in *You and Your Aging Parent* (1982 edition), offer an excellent eight-step process for planning and conducting family conferences. Chapter 10 would be beneficial for all family members to read before a family conference.

---

allow parent to risk

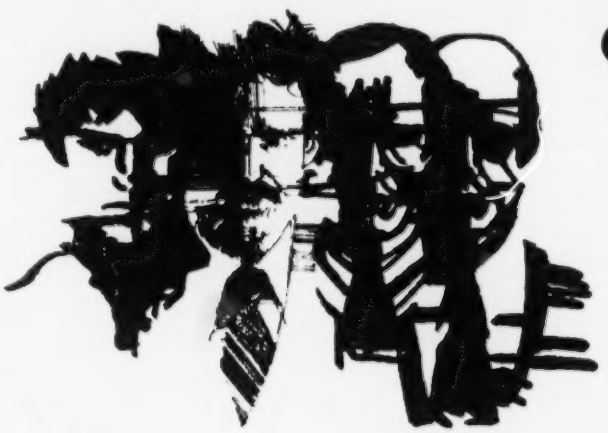
Too much loving protection can undermine an aging parent's self-esteem. The desire to overprotect an increasingly frail parent is natural; however, it's usually the last thing an older person wants or needs.

The goal is to strive for a balance in caring. Don't overestimate your parent's needs; it can be destructive to both of you. If you assume responsibility for functions that your parent can still perform—even if only with difficulty—you're likely to make your parent angry, depressed, or more dependent. People resent forced dependency.

Don't make assumptions such as the following about your parent's abilities, feelings, or needs:

> Mother would be happier if she moved. There are just too many memories of Dad in the house.
>
> Father should not live alone because he can't see very well.
>
> The best place for Mom would be a retirement complex where she'll have to interact with people.

In fact, Mother's adjustment to her husband's death is likely to be more difficult if she is forced to move from her home. Father may have learned to compensate for his loss of



sight. He may function very well in his familiar home environment, as long as family doesn't attempt to "organize his clutter." Mom, who has never been people-oriented, may find living in a retirement complex too crowded and "social" for her tastes.

Also, do not assume that your parent is mentally incompetent just because he or she seems eccentric or refuses to do what you think is "best." Mental incompetency needs to be assessed by professionals.

Before asking or forcing a parent to make changes in his or her life, ask yourself these questions:

- Am I contemplating a protective environment for my parent's sake or my own?
- Are the dangers real or would I just feel more comfortable and worry less knowing my parent is safe?
- Would I feel too guilty if I let my parent take an occasional risk to live independently?

Although your parent's safety is important, it isn't the only factor to consider in making a decision. Reflect on the type of life your parent has lived and your parent's perceptions of the situation. It is just as important to focus on parents' strengths and remaining abilities as on their limitations. Too often focus is only on "What Mom or Dad can no longer do." Limitations should not get in the way of seeing the whole person.

Don't force your values on your parent. What one thinks is "bad" or "best" for a parent is not always true. Sometimes adult sons and daughters are concerned with a parent's "quantity of life" whereas the parent is concerned with "quality of life." If your mother or father is mentally competent and chooses, for example, to remain at home even though you feel he or she would be safer in another living situation, that's your parent's right and choice. If you are worried, express your concerns by using "I" statements.

---

avoid promises and "shoulds"

Don't make promises such as "We'll never put you in a nursing home, Mom" or "You can always live with us, Dad." You may not be able to live up to them. What may seem like the "best" solution now may not be best five or ten years from now when your parent's health or circumstances—or your own—change. Unfulfilled promises often result in feelings of guilt, mistrust, and disappointment.

If your parent's health or living situation deteriorates, you may find yourself bombarded with "shoulds," such as:

- A caring son should invite a parent to live in his home.

- A good daughter should not place a parent in the nursing home.
- A loving daughter should provide care to an ailing parent.

These "shoulds" may come from within yourself, from other family members, or from outside the family. Individuals raised with Judeo-Christian messages such as "Honor thy father and thy mother" and "To love and cherish til death us do part" sometimes interpret these in ways that are self-destructive. "To honor" does not mean to provide full-time care, do everything for a parent, give up a career, destroy one's mental or physical health, or sacrifice other relationships.

It's important not to let old promises, "shoulds," or guilt guide decisions. They reduce objectivity and reduce your ability to make satisfactory choices. You really need to consider what is best for you and your family as well as for your aging parent.

when providing care

Providing care to a frail older parent can be stressful and rigorously demanding, regardless of family commitment. For many, it can be the equivalent of a full-time job or more. Your sleep patterns may change, outside activities you enjoy may be drastically reduced, and you may feel overwhelmed by tasks and responsibilities. The aging person may add to the stress because of care demands, a difficult personality or changes in personality due to illness, annoying personal habits, and in some cases, alcohol or drug abuse.

Previous ways of interacting with the frail person may change. An adult son or daughter, or the healthy spouse of the frail person, may need to become more assertive. This can be particularly difficult if the caregiver has been the passive person in the relationship. These role changes can cause fear, conflict, and confusion for everyone. Frail older persons often resent the burden they create, feel anger and frustration in relinquishing roles, or become demanding in an attempt to regain the control they feel slipping away.

After weighing all the concerns, you may decide that it's best at this time to assume the role of caregiver for a frail parent. It may be a temporary arrangement or it may be long-term. Here are basic guidelines to help you guard against common caregiving pitfalls.

Balance your responsibilities. Caregivers can easily become overburdened in trying to meet obligations and responsibilities to the ill person, to other family members, and to themselves. Before assuming caregiving responsibilities, carefully assess the impact on everyone—children included.

Look at the sacrifices everyone will need to make—as well as the benefits. Don't assume caregiving at the expense of your relationship

with your spouse, your own physical and emotional health, or the welfare of your children. You need time and energy to maintain quality relationships with your spouse and children, whom may be unintentionally neglected.

Meet your own needs. People in a caregiving role frequently place their own needs "on the back burner." Don't ignore your own needs; it's detrimental to yourself and to the person who needs your care. It will lead to "burnout"—a depletion of your physical, emotional, and spiritual resources.

Set limits on what you can do. Most importantly, communicate your needs and what you can and cannot do to your parent and other family members. It's unrealistic and unfair to expect other people "to know" when you need help.

Avoid the "I can do it alone" attitude. It will place you at greater risk for physical and mental illness. Eliminate less critical tasks. Delegate tasks. Ask family members to pitch in, but be positive with your requests and use "I" messages. Ask friends, neighbors, and members of your church or other organizations for help. Seek assistance from volunteer or public agencies that provide services to elders and their families.

Schedule some time for yourself everyday, if only for a half hour. Plan a longer time at least once every week. This isn't always easy to do, but it's important! Leisure time improves morale and energy.

Many people feel guilty about leaving an ill person and enjoying themselves because they have been taught that to focus on one's own needs when a family member is ill is selfish. There is nothing selfish about it. Without breaks in caregiving, you may jeopardize your own health, efficiency, and effectiveness. Your ability to provide loving care will diminish. If you become physically and/or emotionally exhausted, you will find your susceptibility to illness increasing, your problem-solving ability decreasing, your frustrations mounting, and your emotions getting out of control—all warning signals of burnout.

Plan ahead. Realize that the decision to be a caregiver is not a permanent one. There may come a time when you are no longer able to provide care. Consider options—including nursing home or adult foster care—in advance of need.

Be aware of legal matters which need attention and seek professional advice prior to crisis. Make plans for the care of the ill person in case you become ill or die. Involve other family members in these decisions to ease some of the burden.

---

briefly...

There is no easy or "right" solution to the problems people face concerning their aging relatives. Each situation must be treated on an individual basis. It's important to consider the feelings, desires, and needs of everyone. Look at what is best for all and don't let guilt guide decisionmaking. Involve all family members in decisionmaking, especially your older parent. Build on family strengths; then seek help when needed.

Answers to difficult situations sometimes require a professional. A counselor, physician, financial advisor, lawyer, or social worker may be helpful. Involvement in a family support group may also provide answers to problems of caregiving and reduce social and emotional isolation. Sharing with others who are living through the same experiences can promote a sense of "I am not alone" and provide both a source for learning practical skills and an opportunity to vent feelings with others who understand.

Though changes in the later years may be dismaying at times, you can ease the transition by learning about life's stages. We need education to successfully negotiate late-life transitions not only for aging kin, but for ourselves in our own old age. Learning about aging is truly a family affair.

resources

Many publications, available through bookstores and libraries, can help you deal with concerns about aging relatives. These include the following:

Bumagin, Victoria and Kathryn F. Hirn, *Aging Is A Family Affair*; New York, Thomas A. Crowell, 1979.

Mace, Nancy L. and Peter V. Robins, *The 36-hour Day: A Family Guide to Caring for Persons with Alzheimer's Disease, Related Dementing Illnesses, and Memory Loss in Later Life*; Baltimore John Hopkins University, 1981.

Silverstone, Barbara and Helen Hyman, *You and Your Aging Parent*; New York, Pantheon Books, 1982.

Pacific Northwest cooperative Extension bulletins are joint publications of the three Pacific Northwest states—Oregon, Washington, and Idaho. Similar crops, climate, and topography create a natural geographic unit that crosses state lines. Since 1949 the PNW program has published over 200 titles. Joint writing, editing, and production has prevented duplication of effort, broadened the availability of faculty specialists, and substantially reduced costs for the participating states.

This publication was prepared by Vicki Schmall, Extension gerontology specialist, Oregon State University; and Lou Isbell, child and family development specialist, University of Missouri-Columbia.

Published and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914, by the Oregon State University Extension Service, O. E. Smith, director; Washington State University Cooperative Extension, J. O. Young, director; the University of Idaho Cooperative Extension Service, H. R. Guenthner, director; and the U.S. Department of Agriculture cooperating.

The three participating Extension Services offer educational programs, activities, and materials without regard to race, color, national origin, or sex as required by Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972. The Oregon State University Extension Service, Washington State University Cooperative Extension, and the University of Idaho Cooperative Extension Service are Equal Opportunity Employers. 50/50/50

CONCEPT #7: COMMUNITY RESOURCES

Objective 7.1: The student will define the continuum of care and identify the specific services that make up that continuum.

Generalization:

The continuum of care is a full range of preventive, supportive, and restorative services aimed at maximizing the independence and functioning of the elderly client and maintaining that client in the least restrictive environment. Thus, the continuum of care for health services ranges from health education and screening through home health care to skilled nursing care in a nursing home. The level of service provided is dependent on the needs, resources, and functional level of the client.

Strategies and Resources:

1. Have students read and discuss the reading on the Continuum of Care for the Elderly (resource section 7.1). Give each student a case study of an older person or family of an older person with different needs for information or service. Develop 4 to 6 cases and be sure there is a range of needs, i. e. need for information about fitness and recreation programs, volunteer opportunities, in-home health care, nursing care, etc. Each student has until the next class period to identify all resources that might help.

   In the next class, have students who had the same case talk together to pool the resources they identified and then to report to the total class. Discuss:
   - What information sources did they use to identify resources (specific sections of telephone book, bulletin boards, libraries, newspaper, personals columns, brochures, information and referral agencies, etc.)
   - What resources (specific agencies, etc.) did they identify?
   - What problems did they have identifying resources?
   - What was helpful?

   Use this exercise to introduce the concepts of the continuum of care.

Objective 7.2: The student will define the concept of functional ability and relate to the concept of continuum of care.

Generalization:

Functional assessment refers to the measurement of a person's abilities to meet the demands of daily life. This assessment considers both a person's needs and his/her resources for self-care. Depending on a person's functional level, various services may be identified as needed to meet those needs in order to maximize the person's level of independence. As functional abilities change (for example, as a person recovers from a stroke or surgery), the services needed may change to respond to this new level of functioning.

Strategies and Resources:

1. Have a resource person from a community services program for the elderly discuss how needs and resources are assessed to determine the services needed. Ask the resource person to give some specific examples from actual cases of elderly people with different levels of need and receiving different services on the contiuum of care. They could also discuss the range of services available in your community.

   Resource people may come from outreach programs for senior centers or Area Agencies on Aging, the local branches of the Oregon State Senior Services Division, or discharge planning services at local hospitals.

Objective 7.3: The student will appreciate the interrelationship of self-care, family care, and community care.

Generalization:

At all stages of life, people meet their needs in a variety of ways. Typically, adults meet many of their own needs. They may also call on family, friends, and community services. For example, an adult woman may provide for her own transportation to work, but count on school busses to provide for her children's transportation and on police (a community service) to control traffic.

People of all ages benefit from community services (schools, police and fire protection, libraries, recreation programs, hospitals, etc.). Over 60% of the elderly are volunteers in some capacity and as volunteers make a major contribution to families, churches, and civic and community services. If their health fails, the elderly are more likely to become recipients of specialized services and family care in order to remain as independent as possible. Nevertheless, as people age, most continue to rely primarily on themselves for care and secondarily on families and services.

Strategies and Resources:

1. In small groups students list their own needs (food, housing, safety, transportation, education, recreation, etc.) and identify which of these needs are met by self-care, family, friends, and/or community services. Discuss the interrelationship among these sources of care and how some needs are met primarily by self while others are met primarily by others.

   Repeat this process with students looking at their list of needs and projecting which of these needs and sources of care may change with advanced age and which would remain.

2. View the film "The Art of Age" or "Luther Metke" and discuss examples of self-care, family care and community care shown in each.

Objective 7.4: The student will analyze a community and identify services available to its members including the elderly.

Generalization:

Each community has a network of private and public services to benefit and support its members. Some services are available only to certain members, such as church day-care programs only for church members or transportation programs only for the elderly. It is important for people to understand how to identify the services that are available in communities.

Strategies and Resources:

1. Research community services related to older persons. Have students study and research specific need areas relevant to the elderly, including housing, income, transportation, legal assistance, consumer protection, health institutions and recreational activities within the community. Identify all agencies (public and private) and professionals (attorneys, physicians, counselors, etc.) that may meet the elderly's needs in each area. Identify and chart specific needs and services, noting needs that have many, few or no community resources to meet them. Use the handout, "Helping Resources in Aging" (resource section 7.4) to assist the students in identifying possible services.

2. Give students case studies of elderly persons with specific needs. In groups of three have the students investigate specific agencies, services and professionals that could meet these needs. Have students read and use the article "Helping Resources in Aging" (resource section 7.4) to identify possible services.

   Include a discussion on section IV B of this article which focuses on how to contact an agency and make an effective referral.

Objective 7.5: The student will understand that services exist as a result of the political process and that individuals can bring about change by participating in local, state, and federal government processes.

Generalization:

It is easy to assume that needed services have always or will always exist. However, this is not true. In our society community services are created and funded through the political process. Federal, state, county, and city governments are involved in deciding what needs are most important to serve. Even private and voluntary services are influenced by the political process. Advocates for certain groups, such as young children, the mentally retarded, and the elderly, must understand and influence the political decision-making process if services are to be developed and continued.

Strategies and Resources:

1. Have students identify a service or program that they would like to have in their school. They should discuss how they would go about getting this service or program. Discuss specific actions they would take and people they would contact and why. Discuss barriers to obtaining this program or service and why these might be overcome.

   Relate this process to the political process of developing community services for all age groups.

2. After doing Strategy 1, have a resource person from a local community agency serving the elderly come to the class to discuss how that agency came into being, how it is currently funded, and who are its advocates and their actions.

   Similarly, have a senior advocate from United Seniors (a statewide political advocacy group), county commissioners, state legislators, or their representatives speak to the class. Ask them to tell how the students can effectively advocate for services.

3. After doing Strategy 1, have the class visit a legislative hearing on aging services. Other direct observations could be made by visiting United Way board meetings, or local Area Agency on Aging board or County Commissioner's meetings. Check carefully on the meeting's agenda to be sure that the development, continuation and/or funding of community agencies will be directly discussed.

   After observation, have students discuss the factors that were being considered in the meetings, who the important people or groups influencing the process were, and what the students would do if they were the decision-makers.

Objective 7.6: The student will identify careers in gerontology and how other careers are influenced by the elderly.

Generalization:

The field of gerontology has expanded rapidly in the last 20 years and hundreds of specialized careers have developed around serving the needs of the growing elderly population. These careers are as diverse as the elderly themselves, and range from senior center recreation directors and financial planners who work with the active young-old to hospice nurses who care for the terminally ill. Gerontology careers exist in education, social and health services, and private industry.

Beyond gerontology-specific careers, many other careers have been influenced by the growth of the elderly population. Bankers, ministers, dieticians, pharmacists, clothing designers, insurance agents, waitresses, and many others are spending more of their time dealing with needs of older consumers. This trend will continue as the number and proportion of elderly in the population continues to rise.

Strategies and Resources:

1. Throughout the course, have students keep a log of all the careers that they see related to gerontology. Ask each speaker in class to briefly discuss his/her educational and/or occupational background in relationship to his/her current work.

2. Have each student interview people in diverse careers (such as professions, banking, businesses and others) to identify how much of their time and work is spent with the elderly. Students could also ask what skills/knowledge these people feel are important in working with the elderly.

   Have students report to the class, charting their findings on careers that are affected by gerontology.

3. Have students contact community colleges, colleges and universities to collect information about gerontology education.

CONTINUUM OF CARE FOR THE ELDERLY

Clara Pratt
College of Home Economics
Oregon State University
1985

People of all ages benefit from community services. Most communities offer such major services as police and recreation programs, public transportation, and health services. As volunteers, the elderly make a major contribution to many community services. In fact, a recent national poll indicated that more than 60 percent of persons over age 65 serve as volunteers in health, civic, social, or family services.

The elderly, particularly those persons over age 75, are also frequent recipients of specialized social and health services. These services allow elderly to remain active in their community and to avoid unnecessary institutionalization when health or social functioning declines. Because health and social functioning are closely related, social services are critical to the care of old people. A recent study that followed elderly patients for a twenty-month period found that treatment of physical problems alone was insufficient to maintain or restore these patients' well-being. However, coordinated and comprehensive social and health services can have a significant, positive impact on the health and well-being of the elderly.

Three important concepts in the delivery of social and health services to the elderly are:

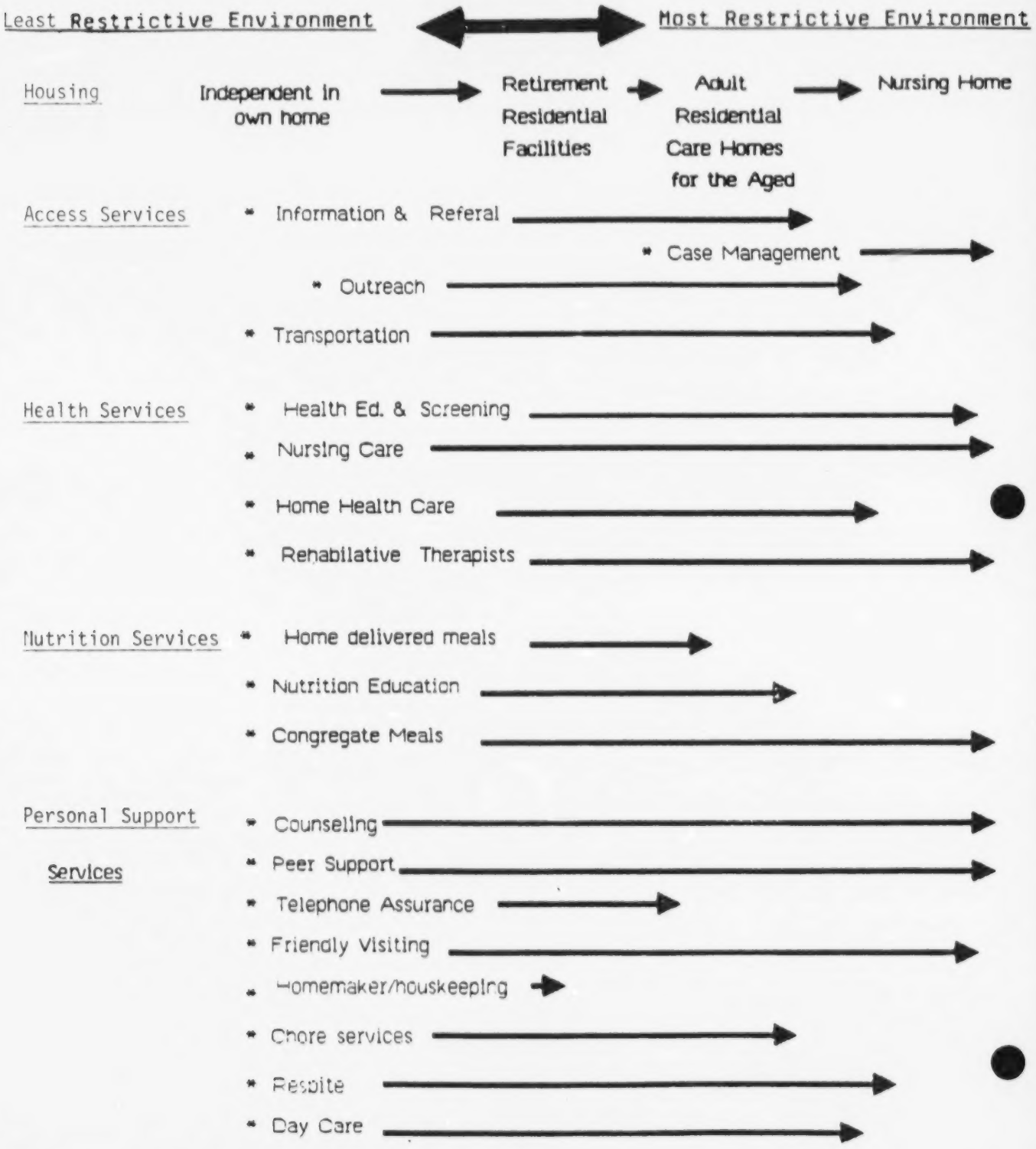
- the continuum of services
- the coordination of services
- the availability or accessibility of services

The continuum of services refers to the full range of preventive, supportive, and restorative services. While not all types of services may be available in every community, the principle behind a continuum is to choose the most appropriate service of those available to maximize the independence and functioning of the elderly client. Thus, the continuum of health services may range from health education and screening programs through home health care, to skilled care in a nursing home. Chart I places some of the most common services on a continuum from independent functioning to institutional care.

Coordination of services is also a critical concept in service delivery. Coordination of services ensures that persons receive an integrated "package" of services appropriate for their unique needs. Coordination of services occurs at both the community level and individual client level. State Programs on Aging and local Area Agencies on Aging (also known as "Triple A's" or "AAA"s) develop and coordinate services for the elderly. First established in 1965 under the Older Americans' Act, AAA's and many of the services they coordinate are jointly funded by federal, state, and local governments. These services typically included most of those found in the continuum of care (Chart I).

CHART I

MAJOR COMMUNITY SERVICES IN THE CONTINIUM OF CARE FOR OLDER ADULTS



In oder to meet the goal of service coordination for individual clients, the local AAA's or some other agency carries out a service or case management function. Case management functions are necessary only for those clients with multiple service requirements. Typically, these are frail, very elderly persons who are at risk of institutionalization. Case management is carried out by professionals, usually social workers, nurses, or gerontology specialists. Steps in case management are:

(1) Assessment of an individual client's needs and resources including physical health, mental status, economic status, and social support.
(2) Development of a service plan designed to meet the needs of the individual client.
(3) Arrangement of services.
(4) Follow-up and reassessment.

Case management enhances the client's capacity for independence and integrates formal services with those resources provided by the client, family, and friends. The resulting service plan typically combines services from several agencies. For example, a client with substantial physical impairments may attend a senior center for lunch and socialization services, use a senior bus for transportation, and receive in-home services such as 'meals on wheels,' personal care (e. g., dressing and bathing), and home-chore.

A third important concept in services for elderly adults is accessibility of services. Because of physical and social isolation, lack of transportation, and lack of understanding and familiarity with services, many old persons do not receive needed services even if such services exist. Access services include outreach services to identify and inform potential clients about services, information and referral, individual needs assessment, case management, and transportation. In most communities, one or two agencies have been established to provide information and referral. These information and referral (I & R) agencies are familiar with all of the other services available in the community.

To find the I & R agency in a particular community, contact:

- the local Area Agency on Aging (AAA)
- the local senior center
- the discharge planner at a local hospital
- the public library

In summary, community services provide vital supports for elderly adults. Community services significantly contribute to the well-being of elderly adults, especially when combined with self-help and support from families, friends, and neighbors. The continuum of care, coordination of services, and access services have a common goal: to maintain the elderly individual at an optimal level of independence in the least restrictive environment.

HELPING RESOURCES IN AGING

I. WHAT COULD THE OLDER PERSON AND THE CAREGIVER BENEFIT FROM?

A. What are the daily living tasks of the older person?
B. What is the older person able to do for him/herself?
C. What are the limitations of the older person you are caring for?
D. What are the needs of the older person?

II. WHAT ARE YOUR RESPONSIBILITIES AND CAPABILITIES?

A. How much time will you have for the older person?
B. What are your strengths?
C. What are your limitations?
D. Communicate with the older person and others what assistance you are able to provide.

III. WHO CAN HELP?

A. Individual--determine what the older person can potentially do for him/herself.
B. Family--determine what the family can do to benefit the older person.
C. Definitions of service providers for the older person.
   1. Adult Day Care: location where services are provided during the day for adults with physical and/or mental impairments
   2. Board and Lodging: housing where meals are provided
   3. Chore Services: provides routine household maintenance tasks
      Examples: cleaning windows, raking, shoveling
   4. Congregate Housing: has multiple units and provides some supportive services
   5. Home Health Aid Services: medical support and personal care provided in a person's home by trained staff under supervision
      Examples: assistance with exercising, bathing, dressing
   6. Homemaker Service: management and personal care services in a person's home by trained staff
      Examples: meal preparation, clean up, shopping, laundry.
   7. Home Nursing Care: nurse performs prescribed treatment at home
      Examples: supervise medications, special procedures
   8. Home Delivered Meals: delivered to homebound persons unable to prepare own meals
   9. Information and Referral: knowledgeable of existing services
   10. In Home Therapy: Provides renabilitative care to a person in the home
       Examples: physical therapy, speech therapy
   11. Intermediate Care: provides minimal assistance
       Examples: supervise medications, assist with bathing
   12. Senior Centers: provides a broad range of activities to older persons
   13. Skilled Care: comprehensive planned care
       Examples: assistance with ambulation, feeding
   14. Telephone Reassurance: telephone contact by volunteers to ensure well being and provide social contact

From: Instructional Manual for Parent Caring Program, Volume 1, Sept. 1984 Duluth, Minn: The College of St. Scholastica. Pages 122-124.

D. Three areas of services providers:

1. In home services
   a. Homemaker
   b. Home Care Programs
   c. Home Health Aid
   d. Chore Services
   e. Home Delivered Meals
   f. Senior Friend
   g. County Senior Adult Services
2. Community Services
   a. County Senior Adult Services
   b. Hospice
   c. Respite Care
   d. Adult Day Care
   e. Senior Citizen Nutrition Program
   f. Community Mental Health
   g. Senior Citizen Centers
   h. Share-a-home
   i. Transportation
   j. Information and Referral
   k. Legal Services
   l. Volunteer Programs
3. Institutional Services
   a. Hospitals
   b. Nursing Homes
   c. Group Homes
   d. Board and Care Homes
   e. Board and Lodging Care

IV. HOW CAN YOU PUT THE DECISION OF HELPING INTO ACTION?

A. Who can refer you to a service provider?
   1. Information and Referral (key to resources)
   2. Social agency
   3. Hospital
   4. Family
   5. Friends
   6. Individual (older person)
   7. Attorney
   8. Physician
   9. Visiting Nurse
   10. Nursing Home
   11. County Senior Adult Services
   12. Clergy person

B. How do you contact an agency?
   1. Do homework before calling
      a. What are the needs of the older person?
      b. What kind of help do they need?
      c. Which agencies will you call?
   2. When calling let the agency know what the older person needs
      a. Be brief, persistent and courteous
      b. Be prepared to repeat request several times
      c. When speaking ask person's name; state why calling; ask if agency can meet the need, is there a charge; summarize all calls
      d. Be prepared to read instructions, fill out forms, and wait

C. Coordinate all efforts involving the older person, the family, and the service provider.
   1. Communicate needs
   2. Understand the responsibilities of all resources involved in the helping process (Who is responsible for what?)

V. IS THE HELP THAT IS BEING PROVIDED TO THE OLDER PERSON EFFECTIVE?

A. Are the needs of the older person being met?

B. Are you able to continue helping the older person?

C. Are the helping resources you are using being effective towards helping the older person?

D. Revise helping services as necessary -- be aware that needs change/services change.

CONCEPT #8: SERVICE-LEARNING

Objective 8.1: The student will actively participate in service-learning activities which involve the healthy and the frail elderly.

Generalization:

Service-learning is a partnership between schools and the community. Through service-learning, students may experience the needs and resources of older persons and community agencies. Service-learning emphasizes both service (such as home visits to frail elders or oral history-taking) and related learning. To increase learning, pre- and post-service sessions should relate the students' first-hand experience to their growing knowledge of aging.

Service-learning can enrich academic instruction by exposing students to the important concepts in gerontology as these concepts are played out in the real world. The cohort effect, young-old, old-old, individual differences, and the importance of life history are just some of the concepts which can come to life as students interact with older adults.

Service-learning projects can be powerful educational experiences. As such, they must be carefully planned to reinforce specific learning objectives. Care must be taken to expose students, especially those with limited experiences with the elderly, to a wide range of older people, not only very ill, institutionalized older persons who may be easily "accessible" in nursing homes. Work with these very frail elders can be an important part of service-learning, but if not balanced with exposure to more active elders, fears and negative attitudes about aging may be reinforced. Because of this potentially powerful impact on attitudes and knowledge, all service-learning experiences require careful planning and supervision.

Strategies and Resources: (Taken from "Curriculum Activities in Aging" by Vicki Schmall and Nancy Benge. 1979. Mimeograph. Oregon State University.)

1. "Adopt a grandparent." This project provides an opportunity for students to establish a close personal relationship with an older person. The class or the students, individually, may wish to adopt a grandparent. Students might be asked to keep a journal recording subjective thoughts and opinions concerning their relationship with the "grandparent" and growing older, in general. Considerations: "Grandparents" for adoption may be located through various sources. (See Resource People for listings.)

   a. It is essential that instructors and students meet with "grandparents" prior to adopting them to discuss expectations and obligations. This would involve an explanation of the purpose, goals and objectives of the project, length of time persons will serve as "grandparents," responsibilities, obligations and commitments students and grandparents have to one another. Any questions students or older persons may have should be answered and clarified at this time.

Also, instructors should periodically check with grandparents throughout the project to make sure there are no problems. These measures should help to prevent any misunderstandings that may arise.

2. Arrange for students to spend time as volunteers at a senior citizens center, retirement home, nursing home or local agency serving older persons. There are a number of services a student volunteer may provide. Such an activity gives students an opportunity to gain new insights into the services provided, an understanding of the lives of independent and dependent older persons, and a valuable one-to-one contact with older persons. The names and locations of various organizations may be found in the Yellow Pages of the telephone directory under headings such as "Retirement Homes," "Nursing Homes," "Senior Citizens Service Organizations," or "Social Service Organizations." A local Area Agency on aging may be able to provide additional information about possible volunteer sites.

   Instructors should be cautious in selecting the sites. It is important to keep in mind that the volunteer experience should be a positive experience for the student. When selecting sites, instructors should check for overall atmosphere/environment, and attitudes of staff and older persons at the site. A student's previous contact with older persons may be an important consideration.

3. Provide services to older persons in the community. This activity provides a service to an older person as well as the one-to-one contact experience. Tasks may include:
   a. General yard maintenance
      (1) pulling weeds
      (2) mowing lawns
      (3) garden work
      (4) raking leaves
   b. General house maintenance
      (1) helping with inside cleaning
      (2) painting
   c. Washing cars
   d. Shopping
   e. Paying bills
   f. Escorting an older person to an appointment

   Considerations:

   a. As mentioned previously, it is essential that students have some training related to aging and old age in order to effectively serve older people and to relate service to learning.

b. Older persons in need of such assistance may be contacted through several sources:
   (1) Senior citizen centers
   (2) local referral centers
   (3) senior organizations
   (4) local ministers
   (5) students who may be able to supply names of persons in need.

c. Once older persons are contacted, they must be informed about the service to be provided. Perhaps this might be done with a flyer, or students could visit the person to explain the service. The older person and the student must have a clear understanding of the responsibilities and obligations involved.

d. Tasks should be closely supervised by a parent or the instructor.

GLOSSARY OF TERMS

This glossary includes some of the terms that are important in gerontology.

Age, chronological: Age measured by the number of years lived from the date of birth.

Age identification: The individual's stage of life as he/she perceives it.

Ageism: Prejudice and discrimination based on age.

Aging: A general term used for various biological, psychological, and social processes by which an individual acquires the socially defined characteristics of old age.

Cataract: Opacity in the lens of the eye.

Cohorts: All individuals of approximately the same age; for example, all persons born in the year 1900.

Continuum of care: Range of services to support person from independent living to institutional care, with the goal of optimum independence in the least restrictive environment.

Demographics: Statistical study of human populations with reference to size and density, distribution and vital statistics.

Developmental task: A prescription, obligation, or responsibility thought to contribute to healthy, satisfactory growth at a particular age.

Functional age or functional assessment: A measurement of the adaptive physical and behavioral capabilities of a person, defining the ability to participate in the environment.

Geriatric: Referring to the medical treatment of old age and its diseases.

Gerontology: The study of aging processes. A field of investigation directed toward understanding the processes of aging and their consequences. From the Greek "geron" ("old man.")

Health maintenance: Describes the goals and services related to disease prevention and the promotion and maintenance of maximum independence of function. Health maintenance uses such techniques and programs as periodic health examinations, multiphasic screening, immunizations, mental health education, accident prevention, and general health education.

Hospice: A facility or program for dying patients and their families which offers support services to manage terminal illness (including pain) and also focuses on emotional care of patients and their families.

Life cycle: The life of an individual seen as a series of stages, such as infancy, childhood, adulthood, middle age, later maturity, and old age.

Life expectancy: The average period of time during which a group of individuals of the same age will live, given current mortality rates. Life expectancy can be computed from any age but is most often computed from birth.

Life span: The theoretical maximum length of life estimated to be about 130 years for human beings.

Nursing home: A group housing facility which offers extensive health care and personal care for residents.

Old-old: The group of people over age seventy-five/eighty; the fastest growing group of the elderly and the major consumers of health and social services.

Older person: Conceptually, an individual in the later maturity or old age stages of the life cycle. Socially, people are usually classified as older if they are over sixty-five years old.

Organic brain syndrome: A mental disorder caused by brain dysfunction or damage. Acute brain syndrome is reversible and often due to inappropriate drug therapy or physical illness. Chronic brain syndrome is irreversible and most often due to Alzheimer's Disease.

Retirement processes: The processes by which the individual prepares for, accomplishes, adjusts to, and lives out retirement.

Senility: An erroneous term for degenerative changes in old people, including illness and weakness, especially mental. Often used without adequate diagnosis and as a derogatory term.

Senior center: An organization for older people offering its members a range of services (recreation, nutrition, education, transportation, referral, and so on) and having a specific facility for this purpose.

Social age: The social role behavior and adjustments expected by society based on an age.

Young-old: The group of people ranging in age from sixty/sixty-five to seventy/seventy-five.

RESOURCE MATERIALS

All the materials listed here have been reviewed and are excellent.

OREGON STATE EXTENSION SERVICE

BULLETINS

Number:

PNW 88	Death: A Family Crisis	.25
PNW 168	Facts and Fallacies of Aging	free
PNW 196	Growing Older: Sensory Changes	.25
PNW 222	Clothing for People with Physical Handicaps	.75
PNW 246	Aging Parents: Helping When Health Fails	.50
EB 828	Cooking for One in the Senior Years	.25
EB 839	Your Will	.25
EC 990	In the Middle Years: Facing Adulthood	.25
EC 1019	In the Middle Years: Turning Points	.25
EC 1020	In the Middle Years: Sexual Fulfillment	.25
EC 1056	In the Middle Years: Changing and Growing	.25
EC 1211	Helping Memory-Impaired Elders: A Guide for Caregivers	1.25

Ordering Procedures

Send requests to: Bulletin Mailing Office, Industrial Building, Oregon State University, Corvallis, OR 97331; or call Bulletin Clerk, Oregon State University, (503) 754-2967.

When ordering priced publications, please add 25 cents for each publication up to 6. When ordering more than 6, please add $1.25 plus 20 cents for each publication beyond 6.

There is a 25 percent discount on orders of more than 100 copies of the same title.

EDUCATIONAL GAMES

FAMILIES AND AGING: A GAME OF DILEMMAS AND DECISIONS
An educational game during which players confront problems, dilemmas, and decisions families face in the later years. 1982.

SEX AND AGING: A GAME OF AWARENESS AND INTERACTION
A game developed to examine participants' attitudes and knowledge about aging and sexuality and their responses to sex-related situations involving older adults. 1980.

Games are $20.00 each and are available from: Oregon State University Extension Service, Ag. Fiscal and Personnel, Ag Hall, Room 136, Corvallis, OR 97331.

COMPUTER PROGRAMS

HEALTH MAINTENANCE, VOLUMES 1 AND 2 - "WELL-BEING IN LATER LIFE"
Students will determine how their current health practices will affect their long-term well-being. Minnesota Educational Computer Consortium. Available from the Oregon Educational Computer Consortium, 700 Pringle Parkway SE, Salem, OR 97310.

FILMS AND SLIDES

"BEST WISHES, EDITH AND HENRY" (18 minute slide/tape)
Presents one family's story about adjustments and decisions adult sons and daughters and aging parents face in later life. Encourages the viewer to explore the range of alternatives that exist in resolving any particular problem. Rental fee $10.00. Available from Gerontology, Oregon State University Extension Service, 161 Milam Hall, Oregon State University, Corvallis, OR 97331. (503) 754-3211.

The following programs will be available early in 1987:

"260 Primrose Lane" - Living arrangement options in later life.

"Due Upon Receipt!" - Planning for financial uncertainties in later life.

"Death of the Dollmaker" - The emotional and physical aspects of caregiving.

"AGING: AN ELDER'S PERSPECTIVE" (4 parts; slide/tape)
Four part series: a couple who want to maintain their independence, a "young-old" person caring for an "old-old" person with Alzheimer's Disease, and a couple in a retirement center. Rental fee: $10.00. Available from Gerontology, Oregon State University Extension Service, 161 Milam Hall, Oregon State University, Corvallis, OR 97331. (503) 754-3211.

PORTRAIT OF GRANDPA DOC (30 minute film)
A young artist recalls his summer experiences with his grandfather and uses these as inspiration for his works of art. Available from Oregon State University, Program on Gerontology, College of Home Economics, Corvallis, OR 97331. (503) 754-4765. (No rental fee, but pay for postage and insurance)

LUTHER METKE AT 94 (35 minute film)
This story takes place at Camp Sherman in Oregon. Luther describes his life building log cabins and discusses his philosophy of life. Rental fee: $20.00. Available from Washington State University and the Educational Service Districts.

PEEGE (38 minute film)
A family visits their dying grandmother in a nursing home. The theme of the film is the difficulty this family faces in communicating and how one young man overcomes this. Use with careful discussion - a very powerful film. Available from DCE, Portland State University Film Library.

AGUEDA MARTINEZ (15 minute film)
The story of a 77-year-old Mexican-American woman on her ranch in New Mexico, making her living by growing chilis and weaving serapes. Demonstrates the impact of life history and culture on aging. Available from the University of Washington Film Library.

THREE GRANDMOTHERS (28 minute film)
A look at the lives of three grandmothers living in very different parts of the world: an African village, a hill city in Brazil, and a rural community in Canada. Considers the role of the grandmother and how her later years may make her a respected member of her community. Available from DCE, Portland State University Film Library.

BIRDS OF WATIADORA: PASSAGE (27 minute film)
Three elderly Japanese-Americans and their life histories are portrayed. Available from the University of Washington Media Center.

ART OF AGE (27 minute film)
"One is under an obligation to live as long as one is living." A philosophy reflected on film in the productive lives of four elderly people. Available from DCE, Portland State University Film Library.

AGING (27 minute CRM film)
Different theories and styles of adaptation to aging. Demonstrates the diversity in how people age. Available from DCE, Portland State University Film Library.

THE MAILBOX (20 minute film)
Older woman looks for infrequent mail from her children. Order from Educational Service Districts.

VIDEO CASSETTES

SEXUALITY IN THE LATER YEARS: AN INTERVIEW WITH GEORGE AND JULIET. (25 minute video)
An interview conducted by Vicki Schmall, Ph.D., with an older couple. George, 76, and Juliet, 72, discuss their feelings about sexuality, their sexual concerns and adjustments as older people, and the importance of obtaining adequate information from physicians about the impact of health conditions, surgery, and medications on sexual functioning. George discusses the effect of heart and prostate surgeries on his sexual abilities. Slides of George and Juliet in a variety of activities are interspersed throughout the video tape to add interest and give the audience a personal view of George and Juliet beyond the interview. Available for purchase for $85.00 from Classroom Television Center, Kidder Hall, Oregon State University, Corvallis, OR 97331-5102, or for rental from Leanna Ott, Oregon State University Extension Service, Gerontology Program, Corvallis, OR 97331. Telephone: (503) 754-3211.

THE METHUSELAH SYNDROME (NOVA series on aging - 52 minute film)
Describes physical, social and psychological aspects of aging with an emphasis on physical aspects. Excellent, especially the first half. Order through Educational Service Districts.

POPULAR MOVIES ON AGING (Available from many video rental outlets)

HARRY AND TONTO
HAROLD AND MAUDE
ON GOLDEN POND
COCOON

MISCELLANEOUS TEACHING RESOURCES

AGING -- A NEW LOOK (Recommended as an excellent resource)
A kit of materials designed to be used with adult groups dealing with issues related to aging. Many activities are appropriate for high school students. Available from American Guidance Service, Publishers' Building, Circle Pines, MN 55014 $42.00.

HELP FOR FAMILIES OF THE AGING: A SMALL GROUP SEMINAR
(recommended/excellent)
A workbook and set of three 60 minute cassette tapes. Many of the activities would be appropriate for high school students. Activities emphasize communication and problem-solving; very involving activities and excellent content. Available from National Support Center for Families of the Aging, P.O. Box 245, Swarthmore, PA 19081 $17.95.

HELP FOR FAMILIES OF THE AGING: LEADER'S MANUAL (see above)
Available from National Support Center for Families of the Aging, P.O. Box 245, Swarthmore, PA 19081 $14.95.

COLLEGE TEXTBOOKS FOR TEACHERS' REFERENCES

Atchley, Robert. Aging: Continuity and Change. Beverly Hills, CA: Wadsworth Pub. 1984.

Atchley, Robert. The Social Forces in Later Life. Beverly Hills, CA: Wadsworth Pub. 1985.

Kart, C. The Realities of Aging. Allyn and Bacon, Pubs. 1985.

Troll, L., Miller S. and Atchley, R. Families in Later Life. Belmont, CA: Wadsworth Pub. 1979.

ORGANIZATIONS AND COMMUNITY RESOURCES ON AGING

1. American Association of Retired Persons
2. American Association of Retired Teachers
3. Retired Senior Volunteer Program
4. Gray Panthers
5. Senior Citizen Centers
6. Retirement Homes
7. Nursing Homes
8. Housing and nutrition projects for the elderly
9. Local branches of State Senior Services Divisions or Area Agencies on Aging
10. Volunteer organizations or referral centers which have lists of older persons
11. Local ministers or the students themselves may be able to provide names of seniors willing to participate